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ABSTRACT

This project explored influences of the service delivery system on the distribution, especially the rural-urban distribution, of mental health practitioners in public settings. Research was planned as a two-phase pilot study--an ethnographic phase (open-ended interviews and day-long observations at 14 mental health agencies) and a survey phase (two-part questionnaire sent to 90 facilities, one part on staffing patterns and another filled out by staff members). With few exceptions, all retention rates appeared high with no clear differences for rural and urban facilities. Urban facilities fared better at filling position vacancies. Rural and urban centers were found to differ from each other and from state psychiatric hospitals in the ways they organized staff and in patterns of utilization. Differences between rural and urban hospitals and between hospitals and mental health centers were also investigated. Standards for job performance and success differed across the facilities. Both rural and urban "successful" centers were found to share a well-defined and clear-operating system of organization and strong community support. (Issues and ideas for mental health program administration are discussed. Suggestions are also made for training of mental health professionals for rural versus urban practice. Instruments are appended.) (YLB)

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STAFF RETENTION and RECRUITMENT

IMPLICATIONS OF STAFF ORGANIZATION AND UTILIZATION IN RURAL AND URBAN MENTAL HEALTH FACILITIES IN THE SOUTH

Final Report:

Distribution of Mental Health Professionals Supplemental Project

Margaret A. Eisenhart and Teresa C. Ruff

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TABLE OF CONTENTS

LIST OF FIGURES v

FOREWORD vi

INTRODUCTION 1

Plan of the Report 4

RESEARCH METHODS 5

The Ethnographic Phase 5
The Survey Phase 10

CHARACTERISTICS OF THE FACILITIES SAMPLED 12

Typical Facilities 12
Retention and Recruitment at Sample Facilities 14

THE ORGANIZATION OF STAFF IN RURAL AND URBAN CENTERS 18

The Official Organization 20
The Operating Organization 22
The Informal Organization 24

PATTERNS OF UTILIZATION IN RURAL AND URBAN CENTERS 24

The Official Pattern of Utilization 24
The Operating Pattern of Utilization 25
The Informal Pattern of Utilization 26

THE ORGANIZATION OF STAFF IN RURAL AND URBAN HOSPITALS 26

The Official Organization 27
The Operating Organization 29
The Informal Organization 29

PATTERNS OF UTILIZATION IN RURAL AND URBAN HOSPITALS 30

The Official Pattern of Utilization 30
The Operating Pattern of Utilization 30
The Informal Pattern of Utilization 31

DIFFERENCES IN THE MEANING OF DOING A GOOD JOB..... 32

Rural Centers..... 32
Urban Centers..... 35
Hospitals..... 37

RETENTION AND RECRUITMENT OF STAFF..... 40

Rural Center 10..... 45
Rural Center 9..... 47
Urban Center 7..... 49
Urban Center 8..... 51
Discussion..... 53

ISSUES AND IDEAS FOR THE ADMINISTRATION OF MENTAL HEALTH PROGRAMS..... 57

Retention..... 57
Recruitment..... 59

SUGGESTIONS FOR TRAINING INSTITUTIONS..... 62

REFERENCES CITED..... 68

APPENDIX A: On-Site Interview Format..... 69

APPENDIX B: Survey Material Sent to Mental Health Facilities..... 81

LIST OF FIGURES

FIGURE 1: All Mental Health Facilities in Southern Region..... 11

FIGURE 2: Retention Rates and Recruitment Success at the Facilities Selected for Visits..... 15

FIGURE 3: Percentage of Each Type of Mental Health Position Vacant All Year in Rural and Urban Facilities During 1978..... 19

FIGURE 4: Percentage of Each Type of Mental Health Position Vacant Part of The Year But Filled During 1978..... 19

FIGURE 5: Model of the Relationship Between External Factors, Staff Organization and Utilization, and Retention and Recruitment--Rural Centers..... 41

FIGURE 6: Model of the Relationship Between External Factors, Staff Organization and Utilization, and Retention and Recruitment--Urban Centers..... 42

FIGURE 7: Model of the Relationship Between External Factors, Staff Organization and Utilization, and Retention and Recruitment--Hospitals..... 43

FOREWORD

In 1978, the Southern Regional Education Board undertook a project to study the impact of training on the distribution of mental health professionals and to make recommendations for strategies that programs training professionals can use to affect their graduates' choice of type and location of practice. Despite an overall doubling or tripling in the total supply of mental health professionals since 1960, the South still finds that professionals are not adequately distributed to rural areas, to certain specialty areas (e.g., child, geriatric, and forensic areas), and to public service settings. Nor are there adequate numbers of mental health professionals from minority groups.

That project, entitled "Distribution of Mental Health Professionals in the South," is focused on the influence of the training programs on the ultimate distribution of mental health professionals. While the influences of the training years are paramount ("As the twig is bent, so grows the tree"), there are many other factors in the service delivery system which also affect the distribution of professionals.

In 1979, the project was granted a short-term supplement to explore some of the influences of the service delivery system on the distribution, especially the rural-urban distribution, of practitioners in public settings. This report is an account of the findings and recommendations from that supplemental portion of the project.

We are particularly grateful to the directors and staffs of the mental health centers and psychiatric hospitals that participated in this project. We appreciate their hospitality and assistance in providing us with data. We also thank the commissioners of mental health in the Southern states and the members of their staffs, as well as the state mental health manpower representatives, for their help in locating sites. Finally, we thank the state manpower representatives, hospital and center directors, university professors, and research specialists who reviewed and commented on the first draft of this report.

We also acknowledge the support of the National Institute of Mental Health, Center for Mental Health Services Manpower Research and Demonstration, which funded this work (Grant #5 T24 MH15477). The interpretations and views expressed in this report are those of the authors.

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INTRODUCTION

In 1978, the mental health program of the Southern Regional Education Board received funding from the National Institute of Mental Health to study the influence of training programs on the distribution of mental health professionals in the South. The major thrust of the project is to investigate the factors associated with training programs for mental health professionals that influence their graduates' choice of type and location of practice, and to make recommendations for strategies that the training programs might use to influence their graduates to choose to work in the areas of highest need. The project grew from the awareness that while the South has doubled and nearly tripled the total supply of professionals in psychiatry, clinical psychology, social work, and nursing since 1960, there are still serious problems in the ways in which these professionals are distributed to rural and inner city areas, to specialty areas such as work with children, the aged, and offenders, and to public service in mental hospitals and community mental health centers. The project focus is on the training programs because they are a major constituency of the Southern Regional Education Board and because a number of earlier studies of the distribution of health professionals had demonstrated the overwhelming influence of the training years on the subsequent practice patterns of practitioners.

The project is conducting surveys both of graduates from 1970 to 1980 and of the training programs to determine what strategies were in place that were designed to influence graduates and which experiences of the training years, in fact, had the greatest influence on the decisions of graduates regarding the locations and types of practice they have engaged in since graduation. The project will then make recommendations regarding recruitment, selection, and training activities which training programs in each of the four core mental health professions might engage

in to influence the distribution of their graduates. These results will be published elsewhere.

Although it has been shown that it is possible to have considerable influence on the distribution of mental health professionals, and that the training years are the key points at which these influences should be implemented, there are, of course, other factors in the service delivery system that influence both geographic and specialty distribution and motivation to work in the public services. The main project at the Southern Regional Education Board was not designed to collect data about the specific effects of the delivery system and service settings on professionals' decisions regarding where to locate, what kind of practice to carry out, or whether to change to a different setting.

The impetus for a short-term supplement to the main project came from a concern in Congress and in the National Institute of Mental Health about what factors were responsible for the uneven distribution of mental health professionals in rural mental health agencies, in contrast to urban and suburban mental health agencies. Additional funds were made available to address this issue of distribution of mental health professionals to public agencies, such as community mental health centers and psychiatric hospitals in rural areas, as compared with those in urban areas. A portion of those funds were awarded to the Southern Regional Education Board as a short-term supplement to the main project, "Distribution of Mental Health Professionals in the South." Thus, Part II of the project (the part described in this report) was designed as a supplement to:

(a) learn about existing staffing patterns in rural and urban public mental health agencies,

(b) investigate the effects of the service delivery system and service setting on practice location and practice change decisions for mental health professionals, and

(c) make recommendations for strategies that might best be used by mental health agencies in rural areas or in inner city areas to influence the distribution of mental health professionals to the needed areas.

Part of the rationale for Part II of the project arose from the fact that, while there has been considerable rhetoric about the shortages of mental health manpower in rural versus urban areas, very little is actually known about the manpower of existing mental health agencies: their personal and educational backgrounds; their working titles and functions; their relationships to each other, to their clients, and to the communities in which they work; their retention rates; or the problems of recruiting them. The Office of Biometry has only limited data (relating specifically to federally-supported mental health centers and to the established professions) about staffing patterns in mental health programs, and nothing about the kinds of functions and roles which staff carry out or the extent to which the agencies are affected by staff turnover and recruitment difficulties.

Our contacts with mental health agencies in the South led us to believe that patterns exist in some facilities which are not generally recognized or characteristic of other mental health programs. For example, we observed that some mental health agencies make greater use of traditional professional job titles than others; some expect their staff to take on a range of diverse mental health activities as needs arise, whereas others expect staff to perform only those tasks in which specific training and credentials have been received; some make significant use of paraprofessionals in direct service roles, whereas others primarily use professionals in these roles. In our region it is increasingly common for jobs to be titled and described by function (e.g. "Case Worker," "After Care Worker") rather than by profession (e.g. "Psychologist," "Social Worker"), but the extent to which various kinds of agencies use functional rather than professional job titles was unknown.

We believed that differences in staff organization and utilization, such as these, distinguished rural from urban mental health agencies in the South and might be significant in professionals' decisions to locate and stay in one setting rather than the other. If these observations were accurate, we believed they needed to be better documented and recognized by training directors, agency administrators, and policy-makers.

Thus, the purpose of Part II was threefold. First, we wanted to determine the existing patterns of manpower organization and utilization in a sample of rural and urban mental health agencies. Second, we wanted to identify those patterns that seemed to have an influence on staff retention and recruitment. Third, we wanted to make recommendations that agencies might use to assist in the recruitment and retention of mental health professionals.

Plan of the Report

The presentation of this research and its findings is organized into three main parts. The first sections of the report describe the methods used to collect the data and the procedures for locating the sites sampled. The main body of the report consists of the sections on staff organization, utilization, retention, and recruitment. In these first sections, we discuss separately the findings on organization and utilization in rural mental health centers (or clinics), urban mental health centers (or clinics), and psychiatric hospitals. We have devoted more time to the discussion of centers than to hospitals because our sample of hospitals is extremely small. The next sections include information on retention and recruitment at typical rural and urban centers. The final sections of the report discuss the implications of the findings for retention and recruitment of staff and offer recommendations regarding these issues.

RESEARCH METHODS

Because of the limited amount of existing information about the ways mental health staffs are organized and utilized, this research was planned as a pilot study consisting of two phases. These phases were designed to complement each other.

The Ethnographic Phase

Ethnographic research is a technique, especially characteristic of anthropology, where the phenomenon under study is observed and described in considerable detail. It depends on direct observation and contact with the culture or situation under study for a sustained period of time. The ethnographic phase of this supplemental project involved open-ended interviews and day-long observations at a small number of mental health agencies (N=14). It was anticipated that the data obtained from these on-site visits would allow us to develop a qualitative picture of the nature of mental health program activity, information that probably would be difficult to obtain through use of more structured questionnaires. Then, these data could provide a foundation for developing questionnaires to go to a larger sample during a second phase of the project.

The selection of sites to visit presented a number of problems. Since the primary purpose of the project was to compare staff organization, utilization, retention, and recruitment in rural versus urban facilities, it was, of course, necessary to select some rural and some urban sites. This necessity raised the question of what constitutes a rural versus an urban locale.

Secondly, the premise of the project was that differences in retention figures and recruitment difficulties would be associated with differences in staff organization and utilization. In order to evaluate this premise, it was necessary to select sites which differed in retention and recruitment success.

In reviewing the literature and talking with practitioners, it was found that no generally agreed-upon definition of "rural" or "urban" locales existed. In general, rural areas in the South have relatively dense populations, compared with the Midwest or West, although these populations are very mixed in terms of social class, social race, and education. Few places are more than 50 miles from a city, and the majority of the population is dependent on small manufacturing and subsistence farming rather than on larger-scale agriculture. Even within the region, however, wide differences exist. What constitutes "rural" in one state might be several quite densely populated counties which lack a population center of more than 25,000. In another state, "rural" areas are those where farm tracts separate isolated population pockets.

The site selection process was further complicated after telephone calls to a number of facilities. Facility administrators indicated that they had incomplete, if any, compiled figures on retention (or turnover) rates at their facilities.

These difficulties, coupled with the small number of facilities designated by the project for research visits, led to the decision to choose from among facilities identified by state-level personnel as typically rural or urban (for their state) and as having particular success or difficulty with retention and recruitment. "Rural" facilities which are obviously atypical, such as those in university towns or in resort areas, were excluded.

Thus, in order to learn about potential facilities in the absence of existing data, commissioners of mental health (or their equivalent) in each of the states were contacted. Obviously, this procedure provided us with a sample biased by the sometimes incomplete or impressionistic information available to these informants and by individual preferences. Since a facility's receptivity to a site visit was also a consideration, we make no claim to have chosen the facilities randomly.

In this manner, a list of facilities, identified as being in rural and urban locales and representing the extremes of retention and recruitment success,[1] was compiled for each of the 14 states of the SREB region (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia).

From this list, 14 facilities were selected and visited between October, 1979, and June, 1980. These facilities included 10 public mental health centers or clinics, and four psychiatric hospitals. Seven of these were located in rural areas; seven were in urban areas. The particular characteristics of these facilities are described in more detail in the section entitled, "Characteristics of the Facilities Sampled."

The visits to these facilities were planned for two days. On the first day, in-depth interviews were conducted with different categories of professional staff. An attempt was made to interview at least one psychiatrist, one social worker, one psychologist, and one nurse. Others were interviewed as time permitted. Since the interviews took approximately one hour, five to six people could be interviewed at each facility.[2] During the interviews, staff were asked to describe their jobs, their relationships to others on the staff, the general ambience of their workplaces, their own career paths, and their own reasons for selecting or rejecting jobs in mental health settings. (See Appendix A for a copy of the interview used during the site visits.)

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[1] See the section, "Characteristics of the Facilities Sampled," for our definitions of "retention" and "recruitment success."

[2] Probably because the number of interviews we conducted was small and because we expressed an interest in obtaining an overview of each facility's operations, many of the interviewees were coordinators or supervisors (e.g., Director of Social Services, Chief Psychiatrist, Nursing Supervisor).

On the second day of the visit, one staff member was observed as he or she went through a daily round of activities. During the observation, a running description of the staff member's activities, encounters, and conversations was recorded. These records provide data on the actual (rather than the perceived) patterns of the work-place. At the rural facilities, observations were conducted of a center director (M.S.W.), a clinical supervisor (M.S.W.), a coordinator of psychological services (M.S., Counseling Psychology), a mental health worker (M.S.W.), a physician's assistant, a caseworker (M.S.W.), and a staff psychiatrist. At the urban centers, a clinical supervisor (Ph.D., Counseling Psychology), a supervisor of the child psychology program (Ph.D., Child Psychology), a head nurse (M.S., Nursing), a mental health worker (M.S., Counseling Psychology), a mental health worker (R.N.), a Qualified Mental Health Professional (M.S.W.), and a psychiatrist were questioned. The final choices of both interviewees and persons to observe were made by the facility directors.

Documents were collected from each site, including organizational charts, job descriptions, and turnover rates for the facility.

In conducting the interviews and observations, several aspects of staff organization and utilization received primary attention. These aspects included:

1) the job duties and responsibilities of staff,

2) the decision-making prerogatives of staff,

3) the support systems available to staff, and

4) staff members' ideas about what constitutes a "good job" and good working conditions.

As we began to collect the ethnographic data, we started to formulate ideas about the similarities and differences between rural and urban facilities, and we tried to associate these differences with retention and recruitment success. The material

we were collecting led us to believe that staffs in rural and urban mental health centers were differently organized and utilized and that they perceived their work in somewhat different ways. We also found that, relatively speaking, the rural centers seemed to have higher retention rates but more difficulty recruiting. In contrast, urban centers seemed to have more turnover and less trouble recruiting.

As we proceeded, we were particularly struck by the fact that each site with a high retention rate seemed to establish a clear operating system in which certain things were valued and rewarded, other things were merely expected, and still other things devalued and discouraged. In order to understand how the facility's organization and utilization patterns impacted on staff retention, we felt it would be necessary to determine the extent to which individual staff members thought they had access to or desired to have the things which were valued in the system of their own facility. By the same token, we began to suspect that recruitment success (to the extent that this success depends on characteristics of the facility and not on factors external to it) would depend on the match between job-seekers' desires for certain kinds of rewards and recognition and their perception of a prospective facility's ability to provide opportunities to obtain these desired rewards.

Interestingly, state hospital staffs appeared to be more similar across sites. That is, the day-to-day patterns of organization and utilization, and the attitudes of hospital staffs appeared to be similar regardless of facility location. Most of the hospitals we visited had lower overall retention rates and had more difficulty recruiting new staff than did the centers or clinics.

These findings, coupled with the information obtained by searching the literature for previous work on this topic (for a review of some of this literature, see Eisenhart 1979), provided the basis for the development of a survey phase of the project. The purpose of this phase was to test our ideas on a larger sample of mental health facilities.

The Survey Phase

Because our interest came to rest on how a facility, as an operating entity, encourages its staff to perceive their work, co-workers, and the facility as a whole, we thought it was necessary to question as many staff members of a facility as possible about their attitudes. In addition, we needed retention figures and some measure of recruitment success for each participating facility. As a questionnaire took shape to address these interests, we realized that we would need quite a bit of information and that it would take considerable time for a facility to compile all the information. Thus, their interest in the project was necessary to ensure the success of the survey.

The desire to obtain as many responses as possible from each participating facility led us to contact the Mental Health Manpower Representative in each state of the SREB region. They were asked to recommend three rural centers, three urban centers, and one hospital which they thought would be interested in participating. In this manner, we obtained a sample of 42 rural centers, 42 urban centers, three rural hospitals, and three urban hospitals, for a total of 90 participating facilities. Figure 1 shows the number of mental health facilities in the region as a whole.

The questionnaire sent to these 90 facilities consisted of two parts. The first part was a survey of the staffing patterns of the facility as a whole. On this form, facility directors or superintendents were asked to report the characteristics of their direct service staff (position titles, fields of training, and degree levels), the 1978 turnover of staff in these positions, and the facility's general recruitment policies, successes, and difficulties. The second part of the survey consisted of a questionnaire to be filled out by each staff member of the participating facilities. This questionnaire asked about the kind of work staff members do; relationships among staff members; and attitudes about the job, the facility, and the locale. (Appendix B contains copies of the materials sent to each facility in the sample.)

FIGURE 1: ALL MENTAL HEALTH FACILITIES IN SOUTHERN REGION

	Urban	Rural	Small City (25,000-100,000)		Total
Comprehensive Community Mental Health Centers	103	50	27	=	180
State Hospitals	33	7	3	=	43
Outpatient Clinics	91	89	12	=	192
Totals	227	146	42	=	415

Forty-one of the 90 facilities (45.5%) returned the facility questionnaire and at least some of the staff questionnaires after one reminder postcard.[3] An additional 14.4% (N=13) sent back staff questionnaires but did not return the facility form. Five of the facilities notified us that they would not participate because of either staff overload or recent upheavals which they felt would bias the results obtained from their facilities. We have not followed up on the remainder of the facilities in the sample.

Breaking down the returns by locale and facility type, 26 of the rural centers (61.9%) responded, compared to 21 of the urban centers (50.0%). Two of the three urban hospitals responded, while only one of the three rural hospitals did so.

In this report, the main purpose is to present the findings of the ethnographic phase. However, figures from the preliminary analysis of the survey results will be included where relevant.

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[3] The percentage of staff questionnaires returned from facilities varied considerably. At some facilities, nearly 100% of the clinical or direct service staff returned completed questionnaires; from other facilities, we received as few as 10%. To some extent, the return rate for staff questionnaires by facility was affected by confusion or inconsistency regarding the definition of "clinical or direct service staff." Although we tried to specify precisely which staff members should receive questionnaires, returns suggest that the criteria were not, or could not be, uniformly applied.

CHARACTERISTICS OF THE FACILITIES SAMPLED

Typical Facilities

Of the facilities visited during the ethnographic phase of this study, seven were located in rural areas or small towns or cities in a rural area, and seven were in urban or suburban locations. Five of the rural facilities and five of the urban facilities were mental health centers or clinics; two of the sites in each locale were hospitals.[4]

From first glance, rural centers and clinics seemed to be set up differently than their urban counterparts. Such differences were not as apparent in the case of hospitals.

Typically, a rural mental health center or clinic serves a five- to ten-county region with a population of approximately 100,000. Total staff normally is from 25 to 50 people, including administrative and support personnel. A central office located in a small town in one of these counties (generally near the geographic or business center of the region) houses the administrative functions for the entire region and the direct service staff who work in that county. Satellite offices, located in the remaining counties of the region, usually are staffed by one or, at most, a few direct service staff, with clerical assistants. These satellite offices offer on-the-spot but a somewhat limited range of mental health services. Staff refer people with special needs to the central office. Generally, the location of the satellite office is considered less desirable as a place to live than the location of the central office. Services offered by rural mental health facilities usually include psychotherapy (individual, group, family), a day treatment program, alcohol and drug abuse programs (most include a residential unit of some

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[4] The facilities visited varied considerably by age of the program, point in the funding cycle, source of funding, etc. Due to the necessarily small sample size and the need to control for rural/urban, retention, and recruitment differences, we were unable to control for many other factors which have been shown to affect the variables under consideration. Some of these differences are, however, noted in the sections on retention and recruitment.

sort), and medication clinics. In addition, these facilities offer evaluation and consultation services to other agencies in the region (e.g., schools, courts, etc.) and to individuals and physicians who request such services. Where in-patient services are provided, patients are usually housed in the local general hospital, in a wing or section set aside for psychiatric care and operated by mental health center staff. As a rule, rural mental health center programs are fairly new (at least new enough to receive federal money and be regulated by federal or state agencies), employ many long-term community residents, and receive significant local support, both in the form of funds and community interest.

In comparison, a "typical" urban mental health center is located in the heart of a large city in a low income area, often in a new, modern complex of service facilities including a general hospital. Most of the 100-plus staff members are housed in one building where virtually all services are provided. The service area for the center includes some portion of the city, usually several square miles and more than 200,000 people. Services offered by the center include in-patient, and out-patient services (therapy, medication clinics, etc.), partial hospitalization, emergency services, consultation and evaluation services, substance abuse treatment with in-patient care, and community education services. Urban center programs tend to have a history of financial and regulative ties to federal and state mental health agencies, employ relatively few long-term community residents, and receive less active community support.

Whether in a rural location or in a city, the hospitals visited were large, multi-building complexes in settings separated from the larger community in which they are located by fences, large tracts of land, or rivers. Patients, often numbering over 1,000 are served by staffs of several hundred people. Hospitals offer long- and short-term hospitalization for chronic and acute patients who have been referred to them either by

public agencies, families, private physicians, or through self-referral. Hospitals provide a wide range of therapeutic, counseling, and living skills' services, medical/surgical services, forensic services, aftercare services, and, of course, round-the-clock general nursing or residential care. Hospital programs are much older (some operating for almost 100 years) than center programs. They also employ large numbers of local residents, primarily in paraprofessional positions. In some rural areas, the hospital is the largest employer. However, major support for these hospitals comes from the state.

Retention and Recruitment at Sample Facilities

Figure 2 shows the retention rates and the extent of recruitment success at the 14 sites visited. Because many of the facilities did not regularly compile retention or recruitment statistics, they had to go back through their records to provide us with figures to illustrate the situation at their facilities. For this reason, our measures of these two variables are somewhat crude.

To obtain a measure of retention, facilities were asked for the number of direct service, clinical, or supervisory positions which had been filled continuously by the same person during the calendar year, 1978.[5] We also asked for the total number of budgeted positions for direct service, clinical, or supervisory staff during that calendar year. The retention rate is the number of positions filled all year, divided by the total number of positions budgeted for that year.

The procedure for defining recruitment success was to rely on the reports and comments of facility administrators and personnel directors. "High" success indicates that

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[5] Where figures were already available or more easily compiled on a fiscal year basis, fiscal year 1978 was used.

FIGURE 2: RETENTION RATES AND RECRUITMENT SUCCESS AT THE FACILITIES SELECTED FOR VISITS

Facility #	Facility Type	Location Type	Retention Rate	Recruitment Success
1	Mental Health Clinic	Small City, rural area	95%	High
3	Mental Health Clinic	Rural	80%*	Moderate
9	Mental Health Center	Rural	24%	Low
10	Mental Health Center	Rural	100%	Moderate
13	Mental Health Center	Rural	97%	High
2	State Hospital	Rural	95%	Moderate
5	State Hospital	Small City, rural area	75%*	Moderate
4	Mental Health Center	Urban	94%	High
6	Mental Health Center	Urban	80%	High
7	Mental Health Center	Urban	93%	High
8	Mental Health Center	Urban	52%	High
14	Mental Health Center	Urban	71%	Moderate
11	State Hospital	Suburban	75%	Moderate
12	State Hospital	Urban	78%	Moderate

*Estimate; complete figures not available.

these spokespersons reported that their facilities had little or no difficulty in recruiting for vacant positions. "Moderate" success indicates that facility representatives report difficulty in recruiting for certain positions (e.g., psychiatrists or social workers). "Low" indicates that a facility reports difficulty in recruiting for a number of different types of positions (e.g., psychiatrists and social workers).

With a few exceptions, the retention rates for all the facilities visited appear, at first glance, to be high. No clear differences emerge for rural and urban facilities. The rural facilities average an 80.9% retention rate, the urban facilities have a slightly lower 77.6% average. The rates are more dissimilar for hospitals (rural = 85% average; urban = 76.5% average).

Interestingly, the data obtained from the survey of facilities suggests that the centers or clinics visited are not atypical, while the hospitals visited may be. In the survey sample, rural centers average a 78.9% retention rate (N=20), urban centers average 75.1% (N=18), the one responding rural hospital reported a 70.6% rate, and the two responding urban hospitals averaged a 61.2% rate.

Not surprisingly, facilities #8 and #9, which had the lowest retention rates, considered their situations to be extremely bad; however, other facilities, such as #3 and #14, with comparatively higher rates, complained of serious problems related to turnover of staff. In contrast, state hospitals, with retention rates close to those at sites #3 and #14, expressed confidence that their rates were acceptable.

This situation suggests the need for further attention to the measurement of "retention" and to what constitutes an acceptable or workable retention rate for mental health facilities. As indicated above and following a report by Ganju of the Texas Department of Mental Health and Mental Retardation, we define retention rate as the proportion of staff members who have been in service at the facility for a given period of time (Ganju 1979:21). In adopting this measure, however, we have bypassed

questions such as: How high a retention rate is acceptable? How high a rate is desirable? Over how long a period should retention be calculated (e.g., one year, two years, ten years)? Is one standard of retention appropriate for all mental health facilities? Are some jobs more "retentive" than others and, if so, is this beneficial or detrimental?

In his report, Ganju discusses other measures, such as the separation rates (proportion of leavers), accession rates (proportion of new hires), and average lengths of stay, which, taken together, give more precise meaning to staff turnover. However, the basic question regarding the level of desirable retention remains unanswered and will require additional research targeted to it.

Our retention figures also heightened our concern about locating facilities with serious and systematic retention problems. We wondered whether state representatives were reluctant to suggest places with such problems or whether, in fact, such facilities are truly in the minority. Clearly, it will be necessary to address the issue of retention rates and problems more carefully in the future.

With regard to recruitment, the urban facilities seemed to fare somewhat better at filling position vacancies than their rural counterparts. This trend is also evident in the survey data. Rural centers, reporting 21% of positions vacant at some point in 1978, had 32.2% of these vacant for the whole year. Urban centers, with 24.7% vacant positions, had 27.4% of these vacant all year. The one responding rural hospital, with 29.4% vacant positions, had 51.4% of these vacant all year. The two urban hospitals averaged 38.8% vacant positions during the year, of which only 20.3% remained vacant all year. Rural centers reported the following distribution of staff vacancies: 8.3% of all vacancies unfilled during 1978 were in psychiatry, 10.4% in psychology, 31.3% in social work, 2.1% in nursing, 8.3% aides, 20.8% direct service,

16.7% supervisors, and 2.1% directors.[6] Urban centers reported 3.4% of all vacancies unfilled during 1978 were in psychiatry, 6.9% in psychology, 13.8% in social work, 8.6% in nursing, 8.6% aides, 44.8% direct service, 6.9% supervisors, and 3.4% directors. These figures, as well as those for the hospitals, are presented in Figure 3. Figure 4 provides information on additional positions that were vacant part of the year, but filled during 1978.

THE ORGANIZATION OF STAFF IN RURAL AND URBAN CENTERS

In visiting the 14 facilities, we found that rural and urban centers differ from each other and from state psychiatric hospitals in the ways they organize staff. In this section, these differences of organization will be illustrated.

The organization of staff can be considered in terms of three types: 1) the official organization (or the relationships defined in job descriptions and organizational charts); 2) the operating organization (the day-to-day relationships established to conduct the business of a particular facility); and 3) the informal organization (relationships between staff which do not involve center business). (Gordon 1957 uses a similar model to describe organizational levels in school; Clement, et al. 1978 offers a modified version of this scheme, again with regard to a school.)

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[6] For the purposes of analysis, staff positions were classified by job title. The classification scheme included 1) professional titles: psychiatrist, psychologist, social worker, nurse; and 2) functional titles: director (overall), supervisor/coordinator, direct service, and aide/assistant. (For further explanation of this general scheme, see Southern Regional Education Board, 1979).

FIGURE 3: PERCENTAGE OF EACH TYPE OF MENTAL HEALTH POSITION VACANT ALL YEAR IN RURAL AND URBAN FACILITIES DURING 1978

	RURAL CENTERS	URBAN CENTERS	RURAL HOSPITALS	URBAN HOSPITALS
Psychiatrists	8.3	3.4	0.0	33.3
Psychologists	10.4	6.9	5.3	8.3
Social Workers	31.3	13.8	5.3	0.0
Nurses	2.1	8.6	0.0	16.7
Aides	8.3	8.6	NA	16.7
Direct Service Workers	20.8	44.8	47.4	16.7
Supervisors/Coordinators	16.7	6.9	15.8	0.0
Directors (overall)	2.1	3.4	0.0	0.0

Percentages do not always add to 100% because non-mental health positions, e.g., teachers, dentists, barbers, etc., are not included.

FIGURE 4: PERCENTAGE OF EACH TYPE OF MENTAL HEALTH POSITION VACANT PART OF THE YEAR BUT FILLED DURING 1978

	RURAL CENTERS	URBAN CENTERS	RURAL HOSPITALS	URBAN HOSPITALS
Psychiatrists	4.0	2.6	0.0	2.1
Psychologists	11.0	78.7	5.6	17.0
Social Workers	5.0	16.0	33.3	2.1
Nurses	7.0	5.8	5.6	12.8
Aides	8.0	5.1	NA	27.7
Direct Service Workers	37.0	44.9	22.2	25.5
Supervisors/Coordinators	24.0	12.8	16.7	4.3
Directors (overall)	0.0	1.3	0.0	2.1

Percentages do not always add to 100% because non-mental health positions, e.g., teachers, dentists, barbers, etc., are not included.

The Official Organization

Both the rural and the urban centers[7] we visited were officially organized hierarchically. Typically, organizational charts are headed with an executive director followed by a number of unit, service, or program supervisors or coordinators of equal rank. Individuals at this second level direct the work of one or more levels of direct service or administrative staff below them. Because urban centers have larger staffs, they tend to have more units of different types and to have more levels of staff, but the general hierarchical pattern is the same in both locales. Job descriptions for the same positions in rural and urban facilities include similar patterns of supervision and responsibilities for decision making and reporting.

Job qualifications for particular positions in the two types of facilities differ, however.[8] Generally, qualifications are closely tied to type and level of education in urban centers. Educational training and degrees in specific disciplines tend to be required for all but the lower-level positions. Generally, responsibilities for directing and supervising staff increase with degree level.

In rural centers, job qualifications for coordinator or supervisor positions are less closely tied to specific educational experiences, often allowing for one of several kinds of training or degrees, or substantial experience in lieu of either. Here, greater responsibility for direction and supervision is more likely to be associated with years of demonstrated experience working in a particular setting or with a particular type of client.

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[7] From here on, when we use the word, "center," we are referring to both the centers and clinics we visited.

[8] This difference seems to be mediated by the degree to which state regulations impact the facility (e.g., how closely tied to the state system the particular facility is) and how strictly the particular state regulates licensing, certification, and salaries. Unfortunately, the small size of our sample does not allow for valid interstate comparisons.

At the official level, both rural and urban centers had considerably more functional titles than professional titles. A similar trend is apparent in the survey data where rural centers reported 36.6% professional titles and 59% functional titles. Urban centers reported 32.3% professional titles and 65% functional titles.[9] In the survey data, there are some differences in the distribution of title types in rural versus urban centers. For example:

Distribution by Functional Titles

	Rural	Urban
aides	5%	6%
direct service workers	31%	40%
supervisors	20%	16%
directors	3%	3%

The resulting ratio of direct service to supervisor positions is, thus, smaller in rural centers (31:20 = 1.55) than in urban centers (40:16 = 2.5). Correspondingly, when degree level is considered, the distribution of degrees in rural centers are as follows:

Distribution by Degree Level

	Rural	Urban
Ph.D./Ed.D./M.D.	12%	11%
Master's	39%	47%
B.A./B.S.	25%	25%

[9] Percentages do not always add to 100% because non-mental health positions, e.g., teachers, dentists, barbers, etc., are not included in these figures.

The master's to doctorate ratios are, thus, 39:12 = 3.25 for rural centers versus 47:11 = 4.27 for urban centers: that is, the numbers of staff at each functional and degree level are more equal at rural than at urban centers. (No differences in ratios were found for professional titles.) Although these differences are not great, they suggest that the hierarchy in rural centers tends to be somewhat flatter than in urban centers.

The Operating Organization

Despite the similarity of official hierarchies, rural and urban centers display different hierarchical patterns at the operating level. The operating organization of rural centers tends to be more "family-like" than in urban centers.[10] In rural centers, some staff members (usually those who exhibit the personal characteristics traditionally associated with power in the South, e.g., whites, men, and older women) assume the duties of providing direction, making decisions, offering support, and supplying information to the rest of the staff. These leaders usually include the director and several other staff members with similar backgrounds, strong community ties, and seniority and supervisory responsibilities at the center. Ordinarily, disagreements over policy and procedures are ironed out among the leaders and then presented to the rest of the staff. Other staff usually accept this direction without argument and, with some exceptions, appreciate it. (Staff were heard to comment, for example, that their leaders protect them from center-wide decision making and paperwork, thus allowing them more time for direct service work.) In this type of organization, staffs divide primarily into a group of leaders and a group of followers. Within each group, members tend to

[10] We had originally thought of describing rural centers as tending to be more "paternalistic" or, in a few cases, "maternalistic." Except for the pejorative connotation attached to these terms, they probably would denote best the character of the relationship we are describing.

function autonomously vis-a-vis each other. Even when relationships such as supervisor-supervisee are officially designated between members of the same group, the operating relationship is one of equals coming together to discuss matters in which one is more knowledgeable than the other. When problems or frustrations arise for nonleaders, they choose to consult with the leader who is personally closest to them, not necessarily the designated supervisor.

While the five rural centers we studied varied in the degree of familistic character they exhibited, we found this pattern to some degree in all five. In urban centers, we found this pattern clearly exhibited at only one site. At the other four urban sites, the operating organization was more congruent with the official organization plan. In other words, urban centers seem to be more bureaucratic and, in a sense, more democratic in their operating organization plan. As officially specified, staff units exercise control over certain activities and related decisions. The unit director or supervisor takes responsibility for arguing the unit's case in regular meetings of center-wide committees or management teams. He or she also takes responsibility for implementing adopted changes and new procedures at the unit level. Similarly, problems and frustrations are raised first with the unit supervisor, not with just anyone who is a leader, as would be the case in the model presented of rural centers.

Usually, changes and new procedures are first presented to the staff for feedback. Feedback is channeled through the unit representative back to the executive or administrative level and a decision is made. We have said above that this pattern is only "in a sense, . . . democratic" because the decision, made at the highest level, need not be reflective of the staff's consensus or even of the views of some of the staff at lower levels. For example, one team leader commented, after the team had spent nearly all of their weekly meeting discussing recommendations for personnel policies which the director had

requested of them, "Rumor has it decisions have already been made." The rest of the team members appeared unsurprised.

The Informal Organization

In rural areas, staff members relate to each other in a number of different contexts, only one of which is the mental health center. Staff members may work together, attend church together, participate in PTA together, and so forth. This means that rural staff have a number of different bases for establishing relationships with each other and tend to have some outside-of-work connection to almost everybody in the center.

In urban centers, relationships among staff are usually confined to the work place. Informal relationships tend to exist within the boundaries of units, services, or programs, where the most opportunities exist for general and/or casual conversation.

PATTERNS OF UTILIZATION IN RURAL AND URBAN CENTERS

Patterns of utilization can be considered in terms of the same three types: the offical pattern, the operating pattern, and the informal pattern. These patterns will be discussed next.

The Official Pattern of Utilization

As alluded to above, job descriptions for rural and urban personnel are quite similar. A typical job description for an urban "clinical social worker," for example, would include: coordinating casework activities within a section or unit; performing clinical counseling; coordinating counseling services; supervising caseworkers; assisting in the planning and implementation of program services, evaluation techniques, and administrative policies; and conducting in-service training sessions. For the M.S.W. who holds this position in a rural center, the officially designated job duties are similar.

The Operating Pattern of Utilization

In order to manage the day-to-day business of rural mental health work, rural staff are often called upon to deviate from their schedules or plans in order to accommodate a walk-in, an emergency, or some other interruption which needs immediate attention. Since, as a rule, rural staff range far and wide from the center's headquarters (main office), almost anyone from secretary to director, who is around when a crisis arises, will be called upon to assist. Further, since professionals in rural places singlehandedly staff outreach offices and make home visits, they are asked to perform many and varied tasks in this capacity as well.

In urban centers, the existence of officially organized emergency services, crisis stabilization units, and a host of nearby agencies means that trained staff are present to handle special situations on a regular basis. This arrangement frees up mental health center staff to conduct their day-to-day routine affairs in a manner more in line with their job descriptions, with the exception that a large portion of their time is consumed with meetings and dealing with the requirements of bureaucratic life.

By virtue of the delineation of specialized tasks and their close proximity to clients, urban staffs are also more likely to be found working in the same office or, at least, the same geographic area every day. They spend relatively little time traveling or dealing with clients in their homes. At one urban site, for example, staff divided their time between two units. This center is associated with a large public hospital and provides psychiatric services to the hospital's patients, as well as operating a short-term, inpatient unit for its own patients. Because staff are often called upon to consult on cases throughout the hospital, they may spend a considerable portion of a day going from one place to another--but always within the hospital/center complex.

Many rural staffers also regularly spend some time each week in an effort to

build and maintain a base of community support for an interest in the mental health center. This work may involve attendance at a local board or commission meeting, invited presentations or talks to community groups, writing newspaper articles, or informal discussions with community leaders. In contrast, urban staffers, as a group, spend little time dealing with the general community, with this activity designated to a particular staff member or program (e.g., Public Relations Specialist, or Consultation and Education Program). For urban workers, contact with the community usually involves interaction with a small group of specialists who are also human service providers (e.g., school psychologists, residential facility operators).

The Informal Pattern of Utilization

Utilizing one's skills outside the business of the mental health center involves different activities in rural and urban locales. In rural locales, after-hours private practice is uncommon, except perhaps for psychiatrists. However, because of the fact that rural practitioners are more visible in the community, they may be called upon to use (or defend) their skills in a variety of contexts (see also Fenby 1980 who describes the pressures to continually be on duty in rural areas).

In urban locales, after-hour private practice (or in some cases, working hours designated for private practice) is more common. Diminished community visibility of urban practitioners means that, when they are not working in the center or in their private offices, they can relax from duty.

THE ORGANIZATION OF STAFF IN RURAL AND URBAN HOSPITALS

Because the rural and urban hospitals were in some ways similar but also considerably different from the mental health centers, our findings concerning them are presented separately. We have, however, used the same conceptual scheme to describe them.

The Official Organization

All the hospitals were organized into a number of separate units or wards where designated staff members were assigned specific duties. While this organizational arrangement is similar, in some ways, to the well-defined program areas found in urban centers, job descriptions for hospital unit positions give even more attention to detailing specific job responsibilities and patterns of supervision than is the case for urban center positions. Perhaps this detailed attention to the system of responsibilities and supervision results from the need to constantly monitor the large number of hospital patients and the more serious (including legal) ramifications of oversights or miscommunications. Psychiatrists are almost always given formal responsibililty for patient care.

The existence of an around-the-clock, dependent population and separate units in a hospital requires that a fairly large number of staff devote their time, primarily or exclusively, to coordinating, managing, and asssessing the activities of these units and their staffs. Hospitals solve this administrative problem by making many staff members responsible to both a unit (or ward) supervisor and to a supervisor for the staff member's profession (such division of labor is rare in urban centers and nonexistent in the rural centers we visited).[11] For example, a social worker assigned to the Acute Admissions Unit of a hospital is likely to be responsible to the unit leader as well as to the director of social services for the hospital as a whole. The unit leader oversees the social worker's performance on the job and as a member of the unit's team. The Service Director provides professional supervision and evaluation. Thus, the individual staff member has a position in two distinct hierarchies - - one which is a function of unit assignment,the other which depends on professional affiliation.

Interestingly, hospital "paraprofessionls," or those with less than a bachelor's degree,

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[11] Clearly, such a division of labor is also a function of size.

are often denied positions in one of these hierarchies because they lack a recognized "professional" affiliation. Thus, one channel of communication with the upper echelon of facility managers is closed to them. This arrangement accentuates the distinction between "professionals" and "paraprofessionals" which is also evident, to some extent, in centers.

Based on the data collected during our visits, we concluded that professional affiliation was given more emphasis in hospitals than in centers. There were, for example, more professional job titles in hospitals than in centers. This finding was supported by the survey data in which hospitals reported an average of 43% professional titles (as compared to 34.0% for centers) and 48.8% functional titles (as compared to 61.9% for centers). Again, we believe that this difference between hospitals and centers can be explained, at least in part, by the greater legal constraints placed on hospitals, particularly the fact that certain common hospital activities must, by law, be conducted by certain professionals.

Additionally, we formed the impression that rural hospitals are organized less in terms of a medical model than are urban hospitals. Comparing the ratios among professional job titles at rural and urban hospitals, it appears that rural hospitals employ proportionally more social workers and proportionally fewer psychologists than do urban hospitals. Further, rural hospitals have considerably more functional titles at the supervisor level than do urban facilities. The exact percentages are: (1) for professional titles at the rural hospital: 12% psychiatrists, 6% psychologists, 12% social workers, 6% nurses; (2) for professional titles at urban hospitals: 18% psychiatrists, 13% psychologists, 5% social workers, 10% nurses; (3) for functional titles at the rural hospital: 35% direct service workers, 15% supervisors, 8% directors; (4) for functional titles at urban hospitals: 25% direct service workers, 5% supervisors, 2% directors. The reason for this difference is not immediately clear to us.

The Operating Organization

Like urban centers, the operating organization of both rural and urban hospitals appears, on the surface, to be bureaucratic and to closely follow the patterns of formal organization. As formally specified, unit directors serve as unit representatives to the overall administration and as advocates for the unit staff when necessary. In this capacity, they attend hospital-wide meetings and relay information between administrators and line staff.

In fact, however, and despite their position as staff representatives, unit directors appear to have less influence than psychiatrists and service directors on hospital operations.[12] Psychiatrists and service directors often constitute a close group of friends who have been working together for years and who frequently convene on the spur of the moment to discuss matters of concern. Within units, as well, staff interact freely and usually treat each other as equals, with the exception of the psychiatrist, to whom other staff frequently defer. In this sense, hospital operations are more similar to the familistic model of rural centers.

The Informal Organization

In the ways in which people interact informally, hospitals are also more like rural than urban centers. Relationships frequently extend beyond the limits of work. People socialize with other staff members and report close friendships with co-workers. These relationships are found in both rural and urban hospitals.

Unlike rural centers where staff relationships often begin outside of work, friendships among hospital staff seem to begin at work and then extend to other settings. One

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[12] Unit directors are almost always social workers or psychologists (by profession); psychiatrists rarely hold this position, nor do they identify with the unit in the same way as others.

reason for this pattern may be that people routinely spend the entire work day in close proximity to their fellow workers and the patients they serve, rather than in separate offices. In addition, an entire unit or team is closely involved with the same set of patients and problems, a fact which provides considerable opportunity for interaction among staff, especially within a unit. While friendships exist across unit lines, these are ordinarily limited by whether the individuals are professional or paraprofessional staff. It is rare for friendships to develop across this division.

PATTERNS OF UTILIZATION IN RURAL AND URBAN HOSPITALS

In discussing how the staff of psychiatric hospitals are utilized, we tried to make use of the three distinctions applied to center staff utilization. However, these distinctions appear to have less meaning in hospitals than in centers. Unlike centers, the operating pattern of utilization in hospitals seems to be extremely congruent with official job descriptions and informal utilization is virtually nonexistent. Perhaps another conceptual scheme would be more appropriate for describing patterns of hospital utilization.

The Official Pattern of Utilization

In hospitals, even more than in urban centers, jobs are assigned on the basis of professional credentials. Responsibilities are designated based on field of training and degree level--rarely, if ever, on the basis of personal preference or talent. People are hired according to strictly defined qualifications and, as described above, job titles are more often in professional terms.

The Operating Pattern of Utilization

In the day-to-day operation of hospitals, there is little deviation from the official

allocation of function. Staff members are assigned to a particular unit where they carry out the responsibilities formally assigned to them. Rarely does someone step outside the boundaries of his or her own job or become involved with another unit. As is the case in urban mental health centers, duties (and roles) are clearly defined and are closely related to the training background of the staff member. Even the few staff, such as the activity therapist or patient advocate, who are required to work across unit lines, have difficulty finding time in the tightly scheduled hospital day to perform non-specialty tasks.

In contrast to centers, lateral job movement is common in hospitals. People are transferred frequently from one unit to another with no change in position level or duties. Seldom does the employee have a choice with regard to this movement. The decision is made by the service director because the person's services are needed more in another place in the hospital. Staff members do not usually complain about this movement; they seem to see it as a fact of life of hospital work. As one nursing supervisor, who had been transferred three times in nine months, said, "If I had had a choice I'd have stayed where I was before the last transfer. But you take what you get and do what you can."

The Informal Pattern of Utilization

Private practice is uncommon among hospital employees, although some psychiatrists do maintain a small private caseload. Even in rural areas, it is unusual for mental health workers to be called upon to use their skills outside the work place. This situation may result from a perception of the hospital as an isolated and contained environment and the only place where one's job skills are legitimately or appropriately utilized. Thus, when mental health workers leave the hospital, they leave their work behind.

DIFFERENCES IN THE MEANING OF DOING A GOOD JOB

During our interviews and informal conversations with staff members, we questioned them about their jobs, co-workers, clients, and facilities. From these data, it became apparent that the standards for job performance and success or, in other words, for "doing a good job," differed across the facilities we visited.

Rural Centers

At rural centers, in the context of the patterns of organization and utilization described above, we have found that mental health workers are expected to measure up to four standards for doing good work. First, it is definitely important to be seen as a generalist. The value placed on one's ability to perform many different functions is expressed almost immediately in interviews with staff at all levels. Staff talk about needing to "do a little bit of everything in this job," and "You have to be flexible on this job . . . you can't get too uptight if you don't get to any of the things you planned to do during a day . . . things just come up and you have to deal with them . . . ." Under these conditions, finding innovative and effective ways to deal with the situations which arise are praised.

Secondly, it is important that rural staffers be willing to step in to take the place of or assist other staff members. Because of the small numbers of staff in any one place at one time, staff believe it is critical to be able to count on any other staff member to make good decisions and to carry out necessary procedures. While many staff comment that they would not feel comfortable with this responsibility without the constant availability of backup, they take pride in being able to handle the situations with which they are confronted.

Thirdly, in the spirit of "familism," it is important for the rural staffer to act like a family member. This standard suggests the need to be responsive to the needs and concerns of other staff members both inside and outside the context of work. Thus, for

example, staff members talk of providing food, babysitting, and temporary shelter for the family of a staffer whose house suffered a fire; another discusses the need to maintain, through support and encouragement, the services of a staffer who has been suffering from depression; a director covers the switchboard so that his secretary can take her sick child home from school.

As a "family" member, the rural staff member is also expected to demonstrate a commitment to the facility and its community. This is the fourth standard. Demonstration of this standard takes three forms. First of all, loyalty to the facility and its staff is important. Staff members who cause dissension, campaign or agitate for change, or speak out against the professional or personal styles of other staff members are criticized. In the "family" of the rural mental health center, it is ordinarily inappropriate, especially for non-leaders, to single themselves out as better than others. In particular, staff members place a strong value on presenting a unified front to the community.

Secondly, it is important that the staff member display a sensitivity to the attitudes and interests of the community from which its clients are drawn. Providing services which are appropriate and approved, particularly as measured by an increase in client numbers, is an important, though often implicit, standard of many rural centers.

Concern for this standard is exemplified in the problems of service provision cited by rural staff. They often describe, for example, the difficulty of overcoming the stigma attached to being mentally ill or the hesitation to seek nonfamily help for problems among rural people. In most rural communities, stigma associated with coming to the mental health center for help is considered high among all classess of people (unless they are recent arrivals from the North or California). Rural staff have many stories about clients from all socioeconomic levels who tried to arrange secret meetings in order to avoid being seen at the mental health center. Others relate how local residents tell them, "Please don't come to see me during the day."

Families in rural areas also complicate the provision of services. Families are seen as having both positive and negative effects. On the one hand, in order to protect the family image, they may harbor a mentally ill person at home, even locked up, as long as the person does not become dangerous. On the other hand, the family is available to offer support and help to the client who is receiving mental health services. One rural psychologist suggested, "Compared to urban, we don't get the really hardcore here because usually some family feels obligated. Mental illness is tolerated in the family here unless violent behavior is associated with it."

Religion, like family, is a factor of Southern rural life which pervades the entire region and which practitioners cannot ignore. On the one hand, religion offers rural residents a support network and a primary context for social activities. On the other hand, it may produce feelings of extreme guilt which can prove to be a source of mental illness. Particularly in areas where fundamentalist religions are strong, mental health workers will be faced with this paradox.

The third demonstration of facility and community commitment involves the ability to adjust one's lifestyle to community norms. Staff frequently mention that rural communities "test" newcomers (and even locals who have gone away to school) to determine if their commitment to the community is serious. By "serious" is usually meant an intention to listen to and respect the community's wishes and to remain in the community for some length of time.

The need to find a way to "fit" was mentioned frequently with respect to questions about what kinds of people are sought in recruiting for vacant positions. For example, a female professional who intends to work while her husband stays home with the kids can become the laughing stock of a rural community (whereas the same arrangement can go undetected in urban locales). Clearly, one's effectiveness and success in a rural area can be limited by such situations.

To accomplish this "match," it is sometimes necessary to endure a great deal of public scrutiny. One single male psychologist described his neighbor's comment on a Monday morning. The neighbor remarked that the psychologist's car had remained in his driveway all weekend. The psychologist responded only by saying, "Yes, my car has been parked there all weekend." However, the psychologist interpreted his neighbor's question to imply: "You didn't have a date this weekend; you didn't go to church on Sunday; and what did you do in your house all weekend anyway?" The staffer reported that such encounters were commonplace and that, luckily, he "lived clean" or he would have had a hard time dealing with this scrutiny on a long-term basis.

Urban Centers

To do a good job in an urban center requires attention to four different standards. First, it is important to concentrate on performing the duties of one's particular position. Staff members comment positively about their colleagues who demonstrate that they can get the job done even in the face of heavy patient loads and paperwork demands. Thus, competency and efficiency together form a standard which is important in urban centers.

Secondly, and closely related to the first standard, it is important to demonstrate a commitment to an academic discipline and to mental health as a profession. Indications of meeting this standard include attending professional meetings, being officers of professional groups, pursuing more specialized training, conducting research and, occasionally, preparing articles for publication. In this context, it is the advancement of professionalism which is stressed. Supporting this finding are the statements of urban staff about needing additional training in order to be "better at our jobs." Even though, in some instances, a job in a particular center is considered only a temporary position along the route of personal professional growth, the center is seen as

a good place to gain important experience. As one M.S.W. put it, ". . .this is a good place to work. We get lots of clinical experience; we see a lot. It is stimulating, a good place to learn." In other words, the emphasis is on improving one's skills and capabilities as a mental health specialist.

A third standard is the ability to work as a member of a "team," as opposed to a member of a "family." In the context of a unit, program, or service, the emphasis is on /one's/ capacity to "carry one's share of the the load," or in other words, to perform duties which complement those of other team members. In this situation, asking others for assistance is discouraged because it can indicate an inability to do the job assigned and it can interrupt the work of others. Similarly, going outside the boundaries of one's own job is discouraged. The initiation of additional activities is risky because it can infringe on another's territory or interfere with one's own ability to perform assigned duties. Each person must have confidence in the ability and willingness of other team members to do their own jobs.

Finally, it is important to know how to maneuver within the bureaucratic structure in order to achieve personal success and to provide good service to clients. Roadblocks to both are perceived to be bureaucratic in nature -- meetings, chains of command, and paperwork. In urban settings, what is important about the environment is that clients suffer from it on a number of levels--economic, social, and psychological--and that they have not learned how to deal with their problems in the tangled system of urban human service agencies. The success of a service provider lies in his or her ability to lead a client through the necessary procedures (including getting the client to see everyone he is supposed to see, filling out all the required forms, and so on) and to teach the client the skills necessary to function autonomously within the system of institutional supports available to him, thereby maintaining his participation in the program. (In other words,

a client who keeps his appointments, takes his medication, and can take advantage of such programs as Medicaid and Food Stamps is considered a "success.") This kind of success depends on the staff member's ability to "work" the bureaucracy: that is, a staff member must know who to talk to and how to present information so that the client's needs are met quickly and so that the time which can be spent dealing with the client's "mental health problems" is maximized. As one staff member expressed it, "You just can't help them with /psychological/ problems until you . . . take care of all these other problems."

In summary, it appears that in order to "do a good job" in a rural mental health center, one must:

1. Be skilled at performing a variety of activities and techniques;
2. Be willing to sacrifice a well-ordered schedule or routine in order to handle the crisis situations which arise;
3. be willing to meet the obligations and responsibilities of "family" membership; and
4. give thought and energy to matching the requirements of the center's programs and the requirements of one's own lifestyle to community attitudes.

In contrast, to do a good job as an urban practitioner, one must:

1. strive for a high level of efficiency in a specialized position;
2. demonstrate a commitment to one's academic discipline and to the mental health field and aim toward increased professional growth;
3. be able to work well as a team member by carrying out assigned activities and responsibilities; and
4. know how and be willing to maneuver within the bureaucratic structures in order to provide good service to clients.

Hospitals

Just as there are differences in the understandings that give meaning to work in

rural and urban mental health centers, psychiatric hospitals have their own standards for "doing a good job." In this section, we describe these standards and contrast them to the standards of rural and urban centers.

The first standard is one shared with urban centers. In hospitals, it is important to perform well the duties of one's particular position. As in urban centers, jobs are specialized and each person is expected to perform efficiently his or her assigned duties.

The second standard, also shared with urban centers, is the ability to work as a member of a team. In hospitals, where a number of staff members share the responsibility for the care and treatment of the same group of patients, teamwork and cooperation are considered necessary to function efficiently. Each person needs to feel that the others are doing the jobs expected. As one activity therapist pointed out, "The staff here on this ward works well together. Everybody knows what their jobs are and everybody expects you to do it." Taking on additional activities or moving outside the boundaries of one's own job is discouraged.

However, unlike urban centers, asking for assistance is acceptable. People feel that the work they do is difficult and stressful and that they need each other's assistance to be successful. Here, teamwork includes giving support to co-workers.

A third standard for hospital workers is the ability to accept the nature of bureaucratic organizations. Unlike urban centers, where people must learn to maneuver within and work around the obstacles presented by it, in hospitals the emphasis is on adapting oneself to its demands and vagaries. People say that one must be "flexible" in order to accommodate constant changes imposed from above and be willing to accept and abide by rules and regulations one has no voice in making.

Finally, as in rural centers, a good staff member must exhibit a strong commitment to the community; in this case, however, the community is the hospital itself. This

commitment is expressed in several ways. The first, and most important, is care and concern for the patients. This concern is demonstrated through the staff member's treatment of patients with respect and sympathy, much like a "good parent." In rural centers, commitment is expressed through responsiveness (to community attitudes and interest) but, in hospitals, commitment is expressed in terms of nurturing behavior.

A second way in which commitment to the "community" is expressed is through length of service. Some hospital staff proudly claim that they are second or third generation employees. One woman (a paraprofessional who was highly respected by both professional and paraprofessional colleagues) told us she has ". . . grown up out here. My mother used to work here, and she brought us to work with her to help entertain the patients." Along these same lines, dependability is highly valued. Dependability is demonstrated by good attendance records, punctuality, and attitude. "She's a delight--been with us for years and always there when you need her" is typical of the positive comments made about co-workers in this regard.

The stigma often associated with mental illness, but especially with psychiatric hospitals, creates the need for a final type of commitment. Hospital staff feel that they must work against the attitudes of outsiders who believe that a mental hospital is a frightening place, full of crazy, dangerous people. Often staff say that they, themselves, were afraid of the hospital before coming to work there, but now say, "It's not a bad place. I wish people on the outside could come here and see what it's like." Even where a hospital has been in existence for many years, staff report that neighbors, family, and friends suspect those who work there. In defending one's work and the hospital against these outside attitudes, the worker demonstrates commitment to the hospital community.

Thus, the four principal standards of performance in a psychiatric hospital may be summarized as follows:

1. be highly competent in a specialized position;

2. be willing and able to function as a member of an interdependent, supportive team;

3. adapt oneself to the demands, changes and inconsistencies of a large bureaucracy;

4. exhibit a strong commitment to the hospital community through concern for patients, dependability, and defense of the institution against outside biases.

RETENTION AND RECRUITMENT OF STAFF

Our visits to these mental health facilities led us to believe that the differences we noticed in the patterns of organization and utilization, in conjunction with some factors external to the facility, gave rise to the differences we found in the ways staff came to understand the "meaning of work" at their facilities. We believed that it was on the basis of these understandings that staff members interpreted their own job performance or success, the relationship of their work and their facility to their own goals, the needs and direction of the facility or program within the facility, and so on. Theoretically, it could also be expected that these understandings would affect retention figures and recruitment efforts at a facility.[13] Figures 5-7 illustrate our ideas about how these various factors interrelate in rural centers, urban centers, and state hospitals. The relationship between staff organization, utilization, retention, and recruitment is presented down the center of each model and is the same for each locale. The boxes around the periphery vary in size to represent rough differences in the amount of influence exerted. Arrows represent the main direction of influence.

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[13] Of course, retention will always be affected to some extent by other external factors, such as a change in spouse's job, funding cutbacks from he federal government, etc. We are assuming that these factors arise randomly; that is, they are not more likely to occur in rural as opposed to urban locales or vice versa. We assume that it is the nature of the work context and the way people feel about their jobs that make these competing situations more or less salient to staff.

FIGURE 5: MODEL OF THE RELATIONSHIP BETWEEN EXTERNAL FACTORS, STAFF ORGANIZATION AND UTILIZATION, AND RETENTION AND RECRUITMENT RURAL CENTERS

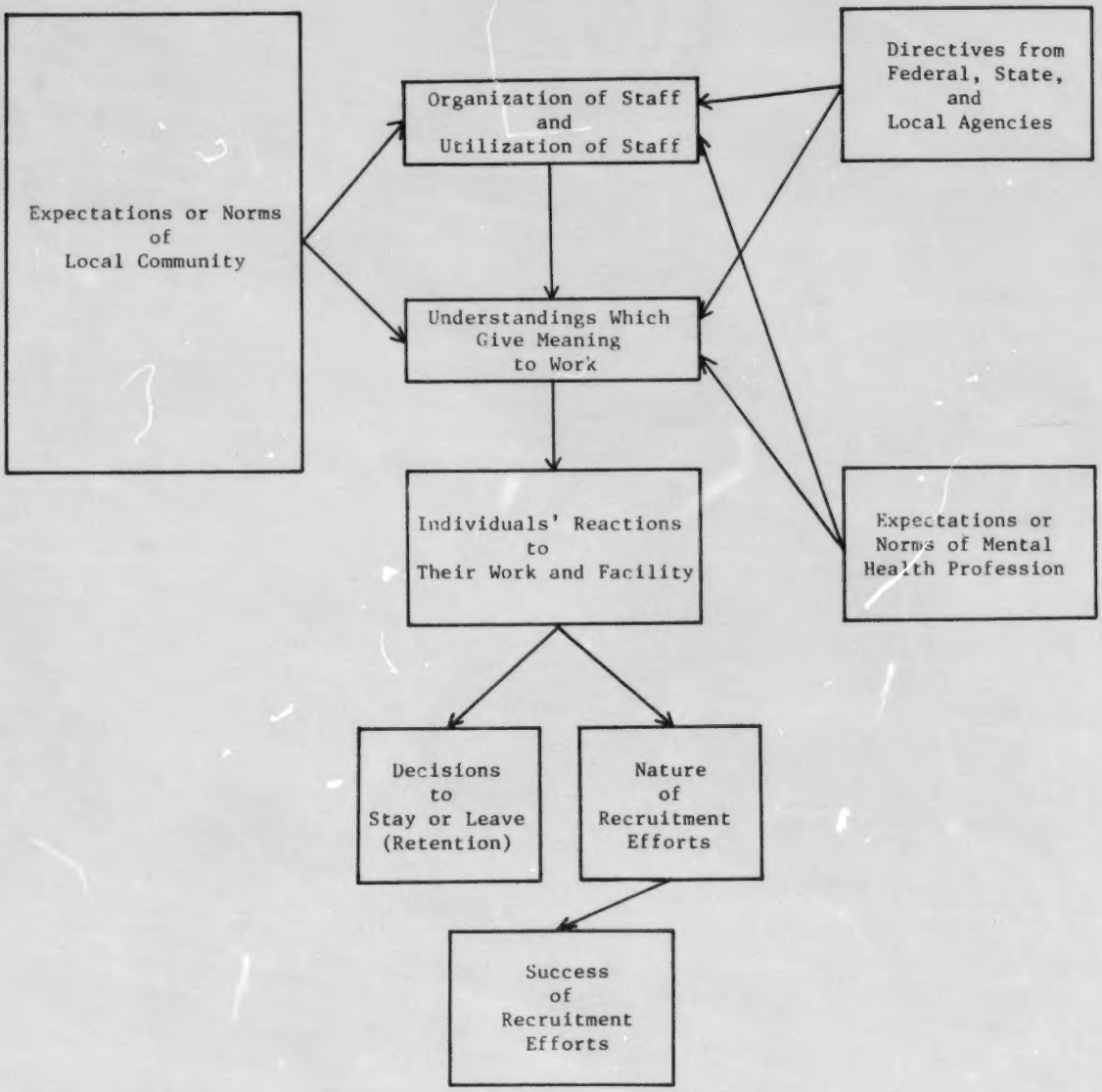

Expectations or Norms of Local Community
Organization of Staff and Utilization of Staff
Directives from Federal, State, and Local Agencies
Understandings Which Give Meaning to Work
Individuals' Reactions to Their Work and Facility
Expectations or Norms of Mental Health Profession
Decisions to Stay or Leave (Retention)
Nature of Recruitment Efforts
Success of Recruitment Efforts

FIGURE 6: MODEL OF THE RELATIONSHIP BETWEEN EXTERNAL FACTORS, STAFF ORGANIZATION AND UTILIZATION, AND RETENTION AND RECRUITMENT URBAN CENTERS

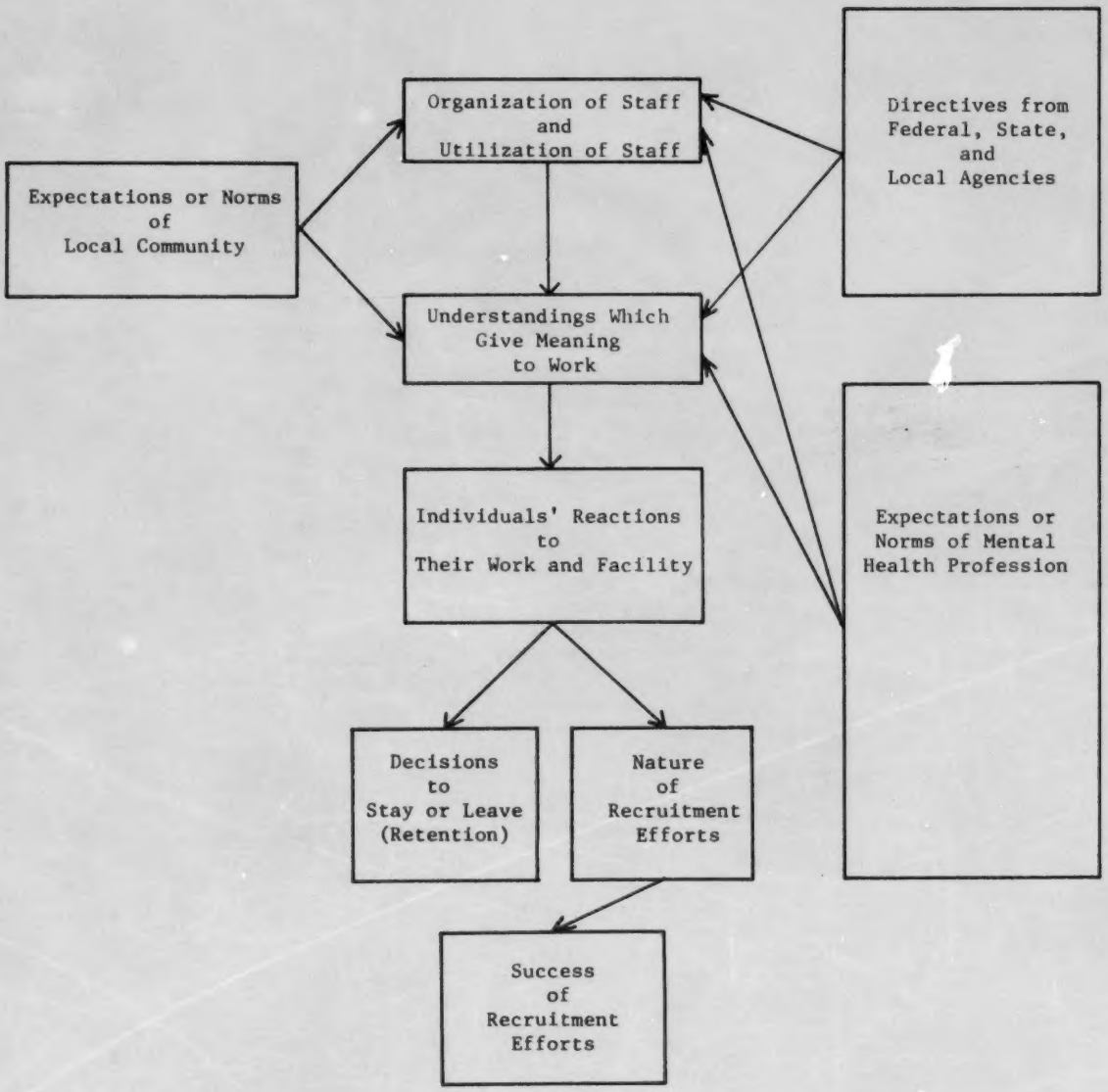
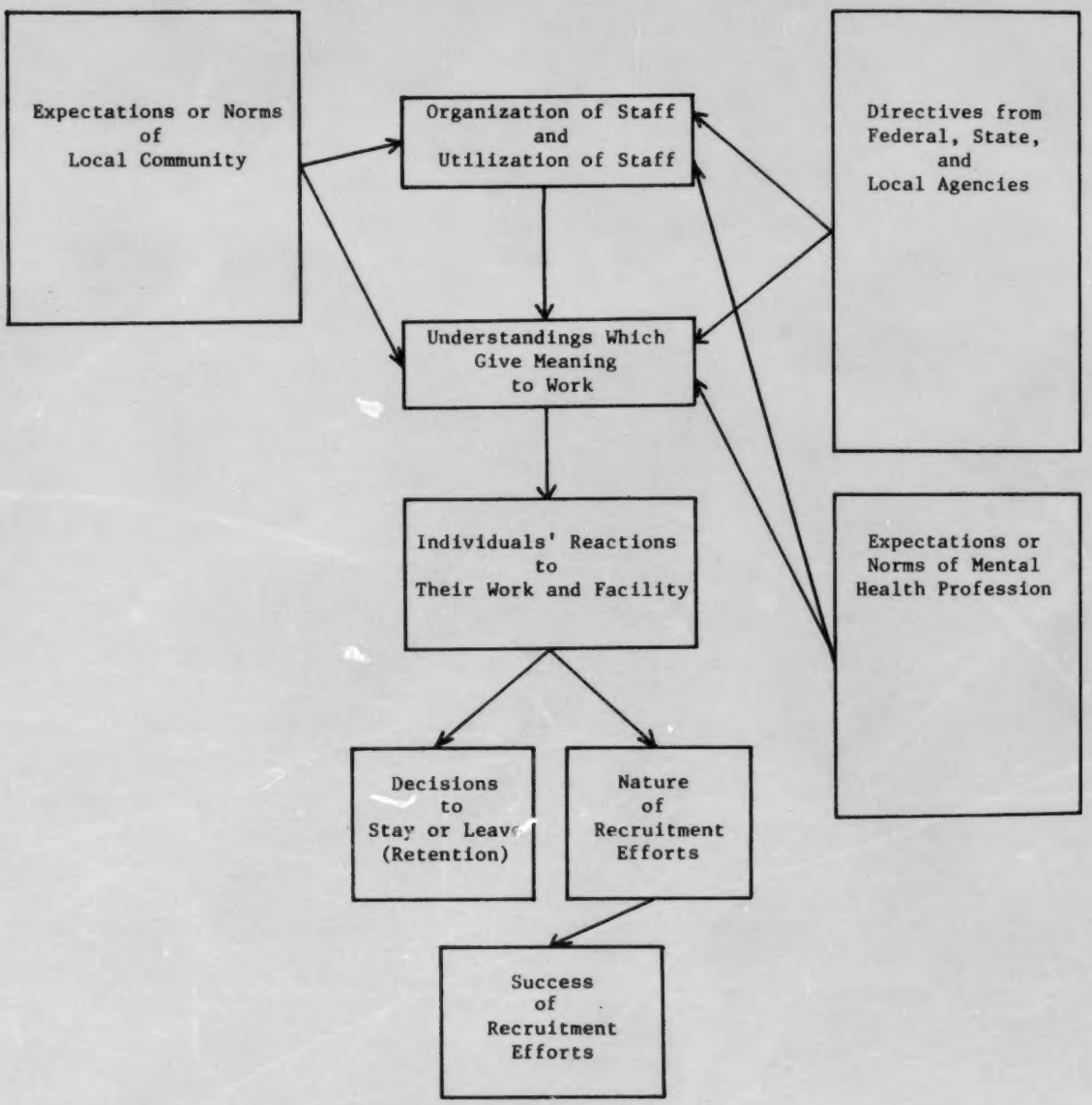

Organization of Staff and Utilization of Staff
Directives from Federal, State, and Local Agencies
Expectations or Norms of Local Community
Understandings Which Give Meaning to Work
Individuals' Reactions to Their Work and Facility
Expectations or Norms of Mental Health Profession
Decisions to Stay or Leave (Retention)
Nature of Recruitment Efforts
Success of Recruitment Efforts

FIGURE 7: MODEL OF THE RELATIONSHIP BETWEEN EXTERNAL FACTORS, STAFF ORGANIZATION AND UTILIZATION, AND RETENTION AND RECRUITMENT HOSPITALS


Expectations or Norms of Local Community
Organization of Staff and Utilization of Staff
Directives from Federal, State, and Local Agencies
Understandings Which Give Meaning to Work
Individuals' Reactions to Their Work and Facility
Expectations or Norms of Mental Health Profession
Decisions to Stay or Leave (Retention)
Nature of Recruitment Efforts
Success of Recruitment Efforts

Building on the idea that facilities establish their own system of meaning comprised of standards for good work and the finding that these standards are different in rural, urban, and hospital facilities, we now hypothesize that staff retention is affected by the extent to which individual staff members can achieve status in the facility where they work. By "status achievement," we mean that the individual perceives that other facility staff (or some "significant others" within it) recognize his or her work as "good" in that context. In other words, "status" depends on one's ability to be recognized for meeting the standards of "doing good work" as defined by the facility, through its patterns of organization and utilization.

If our hypothesis is correct, then we would expect that rural, urban, and hospital staffers would be attuned to different activities, behaviors, and norms in pursuit of status. Specifically, we would expect that rural centers' staffs would desire to be recognized for:

1. skills at a wide variety of jobs;
2. ability to handle crises;
3. behavior as good "family" members; and
4. fitting in or getting along well with the local community.

In contrast, we would expect that urban center staff would desire to be recognized for:

1. efficiency at a particular job;
2. professionalism;
3. ability to work as a member of a team; and
4. ability to maneuver through the bureaucracy.

Finally, we would expect that hospital staff would desire to be recognized for:

1. competence in a specialized position;
2. reliability and a supportive posture as a team member;
3. ability to adapt to bureaucratic changes; and
4. commitment to the activities and goals of the hospital.

Since the meanings and, thus, the nature of the recognition desired are different across these types of facilities, it seems that an individual's reasons for leaving (staying) should also differ, or perhaps more accurately, a given dissatisfaction (satisfaction) should weigh more in one setting. With these ideas in mind, attention was directed to the interview questions which addressed the atmosphere of the workplace, the conditions found rewarding and frustrating there, the reasons mentioned for staying with or leaving one's present job, and the strategies for recruitment.

In the following, profiles of the interview responses from centers 10 and 9 are presented to illustrate the extremes of high and low retention in the rural locales; then, centers 7 and 8 are discussed as examples of the urban centers (see Figure 2).[14] Because the need for recruitment is so closely linked to retention rate, profiles of recruitment efforts at these centers will also be described here.[15]

Rural Center 10

At rural Center 10 where retention was pefect, i.e., 100% during 1978, interviewees' positive comments about their jobs far out-number negative comments. Staff talk excitedly

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[14] Center 4 was not used because it appeared to be unique in a number of ways. Center 7 was substituted because it appeared to be more representative of a "typical" urban center with a high retention rate.

[15] Unfortunately, our sample of hospitals was too small to develop meaningful comparisons.

about the challenges of getting new programs started, new clients enrolled, and managing the new and unfamiliar cases which arise for them. They state that other staff, particularly the director, are highly supportive of their efforts and open to their suggestions. Although a few staff members say that they do not plan to stay at the center for the rest of their lives, they reiterate that they are pleased with conditions at present and with prospects for the future. They report that this optimistic, developmental, and supportive atmosphere is the reason they like to work here and one reason they are not looking for jobs elsewhere. Other reasons include: the lack of comparable jobs in the local area; the idea that, in general, economic prospects are brighter here than in many other regions of the country; and the fact that staff like the value placed on community and family life which they find here. On the negative side, staff express some concern about conservative political attitudes at the state and local levels and complain that such attitudes make increased resources for mental health unlikely.

At this facility, recruitment efforts are aimed at attracting people to newly created positions. Emphasis is placed on finding candidates who have the necessary mental health skills (or the necessary interest to learn the skills during on-the-job training), who are excited about the opportunity to develop new programs, and who will fit in with the existing staff and with the community as a whole. Thus, job notices are placed mainly in local newspapers and magazines where those who are already familiar with the area, by virtue of residence, family ties, property ownership, business, or even vacation trips, may see the announcements. Attempts are also made to obtain names from personal friends who may have local contacts in mental health fields. In advertising positions and encouraging desirable prospects, recruiters peddle both the attractions of the job and the environment (e.g., quality of rural life, low taxes, etc.). Because most candidates are already familiar with the area, the characteristics of the job probably receive more attention as discussions with candidates proceed.

Here the recruitment process is seen as taking considerable time, as diverting staff from other, more crucial mental health activities, and thus, as "expensive" for the facility. Recognizing this "cost," recruiters express considerable concern about the candidate's likelihood to stay with the job and the community for an extended period of time (some say "at least two years" is the minimum expected).

At this facility, it seems that an atmosphere has been created in which it is relatively easy to meet the standards of "doing a good job" as defined in rural centers. It is easy to gain experience with activities of interest because staff are able and encouraged to experiment with new ideas and programs. Staff also find themselves in a highly supportive environment where risk-taking is safe. At this center, being a "family member" seems to be taken for granted: the director is seen as a fair and open-minded head, and the staff as working together to develop a unique and high quality mental health program. Fitting in with the community is not difficult since most staff members already have ties to it.

Gaining the trust and support of local residents for mental health activities may sometimes be frustrating, but community interest in the program and the community's acceptance of the staff as individuals seem to make this work challenging rather than threatening. Finally, considerable attention is given to finding new staff who will fit comfortably into the existing system.

Rural Center 9

Here staff members' comments are more likely to be negative than positive. While staff often begin by saying that they like the challenge of trying to build and improve the mental health program in this area, they go on to say that the many obstacles to be overcome make the job extremely difficult. Prominent in their minds is the future

of the facility which is in danger of closing down if shortages of staff and money are not reversed soon.

In this context, the needs of patients and the concerns of the local community are described as additional burdens to go with the burden of wondering if one will have a job in the future. Most staff members say that they would prefer to work elsewhere if they could find comparable or better jobs. Most are looking for other jobs.

Recruitment efforts here are practically a full-time job for the director. He is determined to turn away from the previous policy of hiring and training local residents (which led to charges of political and personal favoritism under a previous administration). Instead, he wants to hire professionals from outside the local area (which has few professionals of its own). The hiring of professionals is particularly important because staff turnover has resulted in vacancies in key positions, e.g., licensed clinical psychologist, without which the facility's operations are severely cut back. As a result, the director spends a great deal of time in recruitment, in consultation with the local mental health board which is carefully scrutinizing the facility, and in searching for funds.

Because the area is not generally recognized as an attractive place to live (i.e., it has an uncertian economy and is not widely known for its scenic appeal) and because the mental health center itself is not especially attractive in its present condition, generous salaries are used as an incentive to attract professionals. Almost any professional who visits is offered a job. For those who accept without other commitments to the area, however, turnover is rapid. Reportedly, high salaries are not enough incentive to keep someone here in the face of unfamiliar or unpleasant working conditions, a spouse's disaffection with the area, hassles over licensure, or assignment to numerous "undesirable" clients such as alcoholics and "chronics." Staff who stay tend to be those who say that the facility offers special opportunities not usually available elsewhere, such as

professional positions for both husband and wife, and those who have other, non-work-related, reasons for remaining in the area.

In this situation, an atmosphere is created in which it is difficult to do a good job in terms of the standards of rural centers. In the first place, it is difficult to obtain rewards for doing one's job because so much energy is given to meeting crises of service provision, because of the extreme shortage of staff which limit the facility's activities, and because of worries about the future. Meeting crises is viewed as essential, not going beyond the call of duty. Secondly, while there are many tasks to do and too few staff to cover them, existing staff do not have the academic qualifications to perform many of the most essential tasks. In this situation, frustration runs high, as does interest in jobs elsewhere.

Being a member of the facility's family and fitting into the community are also troublesome here. On the one hand, the "family" is without a full-time leader. The director, as almost full-time recruiter, is often not available to give staff the rewards of praise. input to decision making, and the encouragement to design programs which he might otherwise give. Additionally, rapid turnover of staff means that there is little time to develop the ties of family membership necessary to find this relationship rewarding. Finally, the community, defined as both inappropriate as a source of desirable staff members and as somewhat hostile to the center, cannot be expected to be a source of many rewards either. Thus, it is not surprising to find low retention here.

Urban Center 7

Turning now to urban facilities, Center 7 has a retention rate of 93% for 1978. At this facility, interviewees indicate a different orientation toward their work. Prominent in their responses are positive comments about the diversified experiences they

encounter from the range of clients they see and the expertise they feel is acquired as a result. Expertise in clinical skills, administration, and "knowing the bureaucratic ropes" all receive mention. Staff also speak positively about the opportunities for professional growth in which they participate. Many say that they are working on advanced degrees, additional certifications, licenses or credits, or are teaching university classes on the side. In addition, these staff members speak frequently of things they have recently read in professional journals about new therapies, innovative program designs, and what well-known professionals in their field are currently doing. On the negative side, staff mention the hassles of working in a large bureaucratic system but tend to dismiss this rapidly as "coming with the territory."

Staff members here also talk proudly of their facility's excellent reputation in the city. They say that they were attracted to this center after spending time in the area and hearing about how good the center was from others. They seem proud to be associated with such a place and feel that they would have to move to a job in the state or federal bureaucracy, or in a university, to obtain a better position.

Due to the fact that the city and state have frozen hirings,[16] recruitment at this facility is virtually non-existent except for psychiatrists who turn over rapidly, reportedly because they do not like the heavy client load and the restriction on private practice here.[17]

In advertising positions for psychiatrists, the facility emphasizes the benefits of living in a pleasant, growing city rather than the characteristics of the job itself. Whatever the position, however, administrators say that they always search for "top flight clinicians," meaning those with advanced degrees from prestigous Southern schools and those

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[16] This situation was not atypical for urban centers.

[17] Psychiatrists (and other professionals) are required to work full-time for the center.

with administrative experience. Although the state merit system is the formal route to a job at the facility, administrators say they use professional contacts, particularly at universities, to encourage good candidates to get onto the merit roster prior to hiring time. It seems that, when jobs are available, the facility has little trouble finding desirable candidates.

As at Center 10, it seems that an atmosphere is created in which it is relatively easy to do a good job by urban standards. The staff apparently find the pursuit of specialized expertise and professional growth rewarding. Since this facility is located close to universities, in a center of considerable private as well as public mental health activity, and near an airport providing easy access to cities where professional meetings are held, it is not difficult to pursue professional development here. Even staff members with only limited resources or previous academic experience have access to professional development opportunities nearby. Since individuals at all levels of the hierarchy engage in these after-hours activities, it is not considered a hardship to do so. Reportedly, the facility as a whole and its individual members are also frequently recipients of praise from outsiders. During staff meetings, such things as research proposals, program designs, and service beyond-the-call-of-duty are recognized and applauded. Federal and staff officials, as well as local officials, are sources of this recognition.

Urban Center 8

The final facility, Center 8, is an urban center with low staff retention. The topic of greatest concern and frequency here is pressure from the local governing board to cut back expenditures and to improve services. Reportedly, these directives have come in the wake of unfavorable publicity and political maneuvering regarding the facility. One sore point has been the facility's high turnover rate.

Interestingly, many staff focus their frustration over these unpleasant developments

on other nearby mental health centers where, staff believe, more "treatable" clients (e.g., middle class people with mild neuroses and whose chances of improvement through therapy are good) go, more research is done, and university professors like to place their students. Frequently, after explaining all of this, staff will conclude with the statement that their own facility is well-regarded by clients. Pretty clearly, this is not enough of a reward for them.

As at Center 7, hiring, and thus recruitment, is restricted by limited resources. However, unlike Center 7, recruitment efforts here are focused on mental health technicians rather than on psychiatrists. Retaining psychiatrists has not been a problem here, possibly because the center has been moving more toward a medical model in the sense that, in order to cut costs, "expensive" social workers and psychologists are being replaced by "inexpensive" mental health technicians supervised by psychiatrists. Recruitment of mental health technicians has been targeted at new graduates of associate degree programs in local community colleges. Those involved in recruitment report that, initially, prospective candidates are excited by the job because it offers them more responsibility than other jobs for which they qualify. However, once the low pay is mentioned, many job seekers are lured to other jobs by the prospect of higher salaries.

At this facility, one forms the impression that the standards of urban facilities are known and valued but cannot be realized. For example, staff talk about developing expertise and teamwork, but the new pattern emphasizing many individual performances of similar tasks and the one-to-one supervision of the psychiatrist-technician relationship undermine these efforts. Staff comment, for example, that "now everyone (except a psychiatrist) does the same thing here." Similarly, where professional credentials were previously valued because they allowed access to higher status and better paying administrative jobs, credentials are no longer encouraged by a system which stresses the most

direct service for the least money. Morale at the facility is also affected by the poor reputation of the facility in professional circles in the city. In short, it is hard to do a good job here.

Discussion

It appears, then, that both rural and urban "successful" centers share some characteristics which the unsuccessful sites in both locales lack. Both Center 10 and Center 7 share a well-defined and clear operating system of organization. This operating system seems to lead to clear standards for doing a good job, access to rewards for staff members, and high morale which, in turn, encourage retention. Presumably, those who leave are those who, for one reason or another, cannot find a point of access to rewards. In addition, both successful facilities share a strong source of support in the community. For the rural center, this support comes from local residents and is demonstrated by continued client utilization of the facility, the confidence of the local board, and the generally positive attitude of local leaders. At the urban facility, "community" support comes from the professional community, notably other mental health professionals, human service agency representatives, professors, and researchers. It would seem, however, that the two successful facilities would differ in retention rates over the long run. The rural facility's emphasis on community fit would appear to encourage retention over the long run. In contrast, the urban facility, with its emphasis on professional development, would seem to discourage long-term retention.

Turning to the "unsuccessful" facilities, they have more confused operating systems, less clear standards, staff who feel frustrated and unrewarded, low morale, and low retention. Those who stay at these facilities are people who have other reasons for remaining in the community or for whom other local jobs are not available. Both unsuccessful centers also are weakly supported by the community of importance to them. At the rural

facility, local residents are seen as ambivalent, if not hostile, to the facility, and as burdensome for staff. In the urban locale, the professional community holds a low opinion of the facility. Differences appear in the ways these two centers are trying to handle their problems. At the rural facility, more traditional mental health professionals are being sought. The solution here is basically a matter of recruitment. At the urban facility, more paraprofessionals are being sought and the solution is to reorganize the delivery of mental health care to make it less expensive.

On the basis of these data, we propose the following hypotheses for further study of retention:

1. Where access to rewards, as defined by the standards of doing a good job, is easy, retention is generally encouraged.

2. Where access to rewards, as defined by the standards of doing a good job, is limited or blocked, retention is generally discouraged.

3. Where support from the facility's community of reference (i.e., local community or professional community) is forthcoming, retention is encouraged.

4. Where support from the facility's community of reference is missing, retention is discouraged.

In addition, two corollaries regarding rural/urban differences are proposed:

i. In rural facilities, where one of the facility's standards encourages long-term commitment to and fit with the community, retention is further encouraged.

ii. In urban facilities, where one of the standards encourages professional development and moving on and up to "better" positions, retention is further discouraged.

With regard to recruitment effort, we can, at this point, offer only two rather simplistic hypotheses:

1. Where facilities are generally successful (i.e., they have worked out acceptable patterns of operation, clear standards, and retained staff adequately), recruitment efforts will be conservative: they will be designed to attract people who fit into existing patterns and who will meet existing standards.

2. Where facilities are unsuccessful, recruitment strategies will be designed to bring in a new breed of staff member to revitalize the sagging organization.

The recruitment picture is complicated when recruitment success, rather than effort alone, is to be measured. Success at recruiting staff is, essentially, the ability to attract the people you want to what you have to offer. In our work, we asked ourselves if the patterns of organization and utilization and the standards of good work which we found were apparent to potential recruits.

This question proved difficult to answer for two reasons. First, the aspects of organization and utilization as well as the standards we identified as distinguishing rural facilities from urban ones would, for the most part, be "hidden" from prospective staff members. That is, those features would be difficult to determine during a brief interview at or visit to a facility. Also staff did not usually talk about organization or utilization when describing why they initially chose a particular position.

Our data suggest, however, that recruitment success is associated with candidates' previous contact with the local area. At all the sites visited, both rural and urban, most staff members had prior ties to the area. Interest in maintaining or reaffirming these ties was commonly given as the primary reason for choosing a particular job. More specifically, staff members indicated that they looked for jobs in a particular locale because they valued certain characteristics of the locale. They then selected the job they preferred from those offered in the area. This finding strongly suggests that recruitment success is most easily accomplished when recruitment efforts are aimed at those who have to be convinced only of the desirability of the job, and not also of the desirability of the area.

A prior positive attitude about a locale may be especially crucial for recruitment success in rural areas. It appears that, in general, mental health professionals are attracted to the educational, cultural, and social opportunities of urban life rather than to the

opportunities of rural life. In the survey responses, of those professionals contemplating a job change, 28.2% of those working in rural areas said they preferred to move to an urban locale. Only 7.2% of those working in urban areas wanted to move to rural areas.

The second difficulty in discussing recruitment success concerns the long-term outcomes of recruitment strategies. For example, in the case of Center 9 (rural, low retention), the decision to concentrate recruitment effort on traditional mental health professionals from outside the local area seems risky since, if successful even in the short run, it will result in further alienation of the facility staff from the community if strangers are brought in and, subsequently, leave after a relatively short time. Given that the existing staff of Center 9 is small and the facility must, essentially, start over, we wonder if it would not be more beneficial for the facility to concentrate recruitment efforts on people already familiar with the area and on the challenges of the job, of creating new programs, and so on as in Center 10.

Similarly, it is not clear that the current strategy being employed at Center 8 (urban, low retention) will be successful in the long run. The presence of other facilities in the same city where traditional professionals can work for higher status and higher salaries, where "better clients" will continue to go because of these facilities' more "professional" image, where university graduates will try to find places, and where better-paying jobs are available in the community for associate degree graduates, all would seem to work against the creation of a stable staff at Center 8. If turnover remains high as well, community support is not likely to be forthcoming either. We wonder if Center 8 would not be well-advised to rethink its reorganization plan. Specifically, we wonder if Center 8 should: 1) reconsider the utilization of a few advanced degree social workers, psychologists, researchers, and others who would bring greater prestige (both through their presence and their university contacts) and offer some career ladders for paraprofessionals

who want to advance, and 2) make a concerted effort to build an innovative, stand-out, maybe even specialized, program which would attract professional community attention and support.

ISSUES AND IDEAS FOR THE ADMINISTRATION OF MENTAL HEALTH PROGRAMS

Retention

This project has identified a number of issues surrounding staff retention in mental health facilities. First, as discussed earlier, we have found it difficult to uniformly specify what constitutes acceptable or nonacceptable retention. We have found some administrators in facilities with moderate retention figures (relative to all those in our sample) who believe that some staff turnover is healthy for their facilities. We have found others, with high retention figures, who believe services could be improved by still higher figures. We have found still others who wish more of their long-term employees would turn over so as to allow room for new blood. As a result, we are not, at this point, in a position to set a standard for evaluating retention success. We believe, however, that more attention should be given in the future to the whole matter of "retention" programs--to the concept of retention, strategies for retention, and the maintenance of current data concerning retention--in much the same way that recruitment programs or strategies are developed. There has been some concern with staff satisfaction and staff needs assessment, based on the assumption that these are related to retention, but much less effort has gone into developing retention programs than has gone into developing recruitment programs.

Our findings <u>suggest</u> that such retention programs should be fashioned with a facility's system of organization, utilization, and rewards in mind. For example, what constitutes a good retention rate in a rural facility may be too high for an urban facility; what

constitutes a meaningful unit of time for measuring retention in rural centers may be too long for urban facilities. Further, individuals' reasons for staying or leaving rural and urban facilities appear to differ: someone leaving a rural facility after only a short time seems more likely than an urban counterpart to be suffering from difficulties associated with fitting into the community. Perhaps more attention could be given to orienting new staff to the rural community and its norms; perhaps more effort could be given to providing social support to rural newcomers. On the other hand, someone leaving an urban facility after a short stay seems more likely to be trying to move up the career ladder. In this case, ameliorative measures on the part of the facility may be inappropriate or ineffectual. Similarly, a person who stays a long time in a rural facility may be developing important community trust, while someone who stays a long time in an urban facility may be stagnating. We believe that issues and questions such as these beg for consideration and further research.

In the absence of a standard for evaluating retention, we can, however, offer some suggestions for facility administrators who wish to change retention figures at their facilities. Our findings indicate that in places where retention rates are high, the patterns of operating organization and utilization are well-defined and routinized. One consequence of this clarity seems to be that the standards for doing good work are also clear and recognition for work well done is, in some way, available. In contrast, in facilities where retention rates are low, the patterns of operating organization and utilization are confused, resulting in ambiguity about standards and difficulty in obtaining recognition for work done.

On the basis of these findings, it would appear that retention rates are vulnerable to the extent to which the operating system is not clearly discernible. For administrators wishing to increase retention rates, we suggest an examination of the existing operating system. If staff members have not worked out smooth and effective ways of apportioning

tasks and taking responsibilities, can measures be implemented to improve conditions? Such measures might include designating or hiring a leader or group of leaders to give units a sense of direction and purpose, establishing more rungs in the career ladder, implementing administrative changes designed to give units more flexibility to define and control the work done in them, or developing mechanisms for dealing with territorial disputes and inequities between categories of staff. In all cases, the ultimate purpose of the changes should be to make staff feel better about the work they do.

Where too much retention is considered a problem, several alternatives are available. For one, in-service programs and staff development may help to motivate tired staff members. Administrators might also cooperate with other local human service agencies in order to increase opportunities for lateral transfers between agencies. Encouraging professional development might also serve to keep staff moving.

Our findings also suggest the importance of community support if facility operations in general and retention rates in particular are to be satisfactory. Where community support is lacking, more attention could be given to public relations, to programs targeted to specialized interests or needs identified by the community, and to staff contact with community leaders.

Recruitment

As discussed above, our findings suggest that recruitment efforts are, in general, most effective when aimed at mental health specialists already familiar with the locale in which the job is located and when the challenges of the job and the qualities of the facility, rather than external influences, can be the focus of attention during job interviews.

At this point, we would like to offer a few additional observations on the general

problem of recruiting staff. These observations are based on our impressions of the kinds of staff who look for new jobs and of the kinds of things they look for. These observations also refer to features of the recruitment situation which the facility might be able to effect.[18]

First, job seekers appear to fall into three main categories. There are those who have just completed a degree program and are looking for their first (or their first in this field) job. Oftentimes, new graduates have little experience by which to evaluate job possibilities. In cases where new graduates are in oversupply, they are likely to take any job which is offered to them. Once in the job, these new graduates often discover that the job or the facility is not providing the rewards expected, and the person begins to look for another job.

The new graduate can present several problems for facilities which have difficulties filling vacancies. First, the new graduate in oversupply is apt to search for jobs in areas which he or she knows are not favored by more experienced people. There are usually more jobs available and advertised in these areas (e.g., rural areas, geriatric settings, etc.) for the same reason. Unfortunately, the new graduate is less likely to know what he or she will find in a job in these areas. In this case, since the new graduate may accept a job offer quickly, the facility may want to develop a means of carefully screening new graduates to determine whether they are likely to enjoy the job and stay in it.

For rural facilities attempting to fill vacancies, the likelihood that new graduates will be unprepared for rural practice is high. The findings from a survey of 591 graduates of B.S.W. and M.S.W. training programs, being conducted under Part I of this project, provides a case in point. When asked to indicate the amount of didactic training received

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[18] Thus, other factors contributing to recruitment, such as career aspirations of a spouse and presence in the job market of a few chronically dissatisfied, yet experienced, mental health nomads, are not considered here.

in 25 different areas, training in rural/urban differences appeared 15th on the list; with respect to field experience, rural/urban differences appeared 18th on the list. In both cases, training in rural problems appeared below training in problems of all other special groups, except Chicanos. In addition, while respondents said that they spent 43.5% of their time prior to entering their mental health training programs in urban locales, they reported spending 72% of their training period in urban locales. Thus, rural administrators may want to take special pains to evaluate the match between their facilities' work standards and the expectations and experiences of new graduates. Concentrated orientation programs for novices may also prove a worthwhile investment.

The second type of job-seeker is the person attempting to make a mid-career change. These individuals usually look for hefty benefits associated with a career move. In other words, they may want substantial salary increases, more opportunities for career advancement, more opportunities to do the kind of work they desire, more vacation time, and so on. The facility seeking a mid-career person will have to deliver many or all of these benefits up front, in order to attract the person. At least compared to new recruits, however, it appears that mid-career job-seekers are more certain about what they want from a job and, once these conditions are met, they are more likely to stay at the facility. Perhaps, because of limited resources and the diminished value placed on professionalism in rural places, they rarely attract mid-career job seekers. It might be cost-beneficial to provide more in terms of salaries and benefits so as to attract experienced mid-career people likely to remain at a rural center, rather than recruiting and training new graduates from urban-oriented programs who are likely to leave after a short (and, therefore, relatively costly) stay at the facility.

The final type of job-seeker is the person making a change in the later stages of a career. Commonly, this person is looking for work which is less frantic, less demanding,

or less time-consuming than previous work. To get this type of position, the later-career person is often willing to take something less than the highest benefits he or she could command. Possibly because of the stereotypic image of rural America as a slower-paced environment, we found a number of people, now working in rural places, who had spent the major portions of their careers in urban places.

For these reasons, then, individuals in the later stages of their career may prove to be a good bet for rural administrators seeking new employees. While this group of job seekers is highly experienced, they often do not make the demands, which are hard for rural facilities to meet, of mid-career job seekers. On the negative side, these individuals may also be set in their established routines and may have difficulty adjusting to a new environment, new techniques, and new definitions of need.

SUGGESTIONS FOR TRAINING INSTITUTIONS

Assuming that at least some training institutions are trying to prepare students for existing positions in mental health fields and that these institutions would like their graduates to feel useful and valuable in their places of work, institutions training mental health professionals will be interested in the implications of these findings. Importantly, the findings suggest that adequate preparation for work in rural areas differs from the training required to perform well in urban areas. In this section, we will present a few suggestions, based on our findings, for the training of mental health professionals for rural versus urban practice.

In the case of rural facilities, many currently have position vacancies. According to rural facility administrators, these vacancies occur for two reasons. First, it is often difficult to find anyone possessing the qualifications required by law for some positions. Secondly, administrators of rural centers often express concern about finding applicants

with the qualifications the administrators themselves require. These qualities include such things as the ability to work as a generalist, the ability to remain flexible, and the ability to fit into a community, which have been mentioned above as conditions of work in rural places. Thus, while some rural centers have plenty of applications for vacant positions, they still have trouble finding someone they "really like" to fill the position. Given this situation, training institutions might assist both in the placement of their own students and in the better distribution of professionals to places where they are needed if curricula were designed to give more attention to the requirements of a rural work setting. Such assistance might be provided in the following six ways.

1. Since it is important for rural staffers to be generalists, training programs in psychiatry, psychology, social work, nursing, and other professional fields could provide a curriculum track which is aimed at preparation for "general" mental health or human services practice. Such a curriculum orientation might follow the plan used in training general physicians or family physicians. The goal of the track would be to provide students with the knowledge and experiences necessary to perform well in a variety of areas rather than being oriented to only one or two skill areas.

2. In designing this more general curriculum track, at least a portion of it should be devoted to the patterns of organization and utilization which can be expected in rural places (this might be incorporated, for example, into a section of the track which also discusses differences between public and private practice, mental health center and child welfare agency practice, and so on).

3. Further, a course should be offered which provides students with a qualitative understanding of what it is like to live in a rural place. We are thinking here of fiction, nonfiction, and poetry which gives a feel for the rural South (such as Reynolds Prices' A Generous Man, for example).

4. Because of the concern about community support in rural places, some classroom attention should also be given to innovative techniques for determining appropriate services for hard-to-reach clients. Peacock (1975:199), for example, has suggested that Southern whites have not been interested, historically, in social reform movements, but favor instead change through dramatic conversion experiences. The use of such experiences, already apparent in some programs such as alcoholism treatment, might be expanded for use in centers in the rural South. A number of the people we interviewed made suggestions regarding a broader base of services for rural centers. Heading this list is the idea that the name of the facility might be changed. Suggested changes included "Human Growth Center" or "Human Development Center." An example is Kentucky's "Comprehensive Care Center." Under a new name such as one of these, staff members proposed exercise classes, diet counseling, financial planning, community planning, and non-smoking clinics as means of improving the mental health of rural citizens without the stigmatizing effects of targeting a program at "mental illness." Training institutions could contribute to these efforts by instructing students in techniques for systematically

determining clients' needs and clients' understanding of what service provision should entail. (For an explanation of an innovative methodology to determine client attitudes, see Harding and Clement 1972; for examples of programs established to maximize community input and, thereby, design appropriate services, see the articles on the Dade County, Florida, Mental Health Units in Psychiatric Annals, Vol. 5, No. 8, August, 1975.)

5. Also in regard to rural service provision, training institutions could give attention to recruiting minority group members and minority classs members, encouraging them to work in rural settings, and preparing them for what they will find there. Shortages of minority staff existed in all the rural centers we visited, the problem made worse by the fact that so many rural residents themselves fall into minority groups and classes.

6. Lastly, since it is difficult for students to obtain knowledge didactically of how rural mental health centers actually work, we feel that each profession's "general human services" track should include substantial time for rural field placements. This is especially important since, as mentioned earlier, the overall orientation of the mental health professions is primarily urban. Social work, for example, is overwhelmingly urban in standard textbook content. Rural relevance is primarily the result of specific adaptations instituted by a few social work training programs.

   We suggest that field placements occur throughout or during the

program, not at the end. Placements occurring at the end of training cut off opportunities for students to discuss and think about their experiences with professors and also cut off the educational institution's source of information about the work situations its graduates will face. Another option would be to run a seminar concurrently with a senior-year placement. This arrangement is possible when students and professors are located in close proximity.

Field placements could also be designed so that the recipient facility receives some benefit, other than the intern's services, which are often seen as more of a hindrance than a help due to his or her inexperience. One idea which might have appeal in rural settings would be to provide a center staff member with advanced training in exchange for the facility's willingness to train the intern. Since rural staff are often located far from universities, they find it hard to pursue academic work and feel that their level of expertise and motivation diminishes with time. By exchanging didactic training of staff for field training of students, institutions could benefit both parties.

In urban centers and some hospitals, retention is as much or more of a problem than recruitment. Here, high turnover is usually associated with the difficulties of working within a large bureaucracy and the emphasis on "moving on" to better positions elsewhere. Since some mental health programs suffer from such high turnover rates, we feel that training institutions might consider ways of preparing students to cope effectively with urban bureaucracy.

1. One way to better prepare staff for the urban bureaucracy might be to devote classroom time to how bureaucracies work, and particularly to how they work to thwart staff morale and innovation. Coursework could also include consideration of whether such bureaucratic structures are appropriate for human service delivery and, if not, how the provision of services in urban areas might be altered.[19] (For information on these subjects, see, for example, Gruneberg's 1979 book which reviews recent findings on staff morale and bureaucratic structures.)

2. Alternating periods of field placement in urban agencies with classroom work is also suggested as preparation for urban work. Since many center staff enroll in university classes in urban settings, these classes provide opportunities for novices and oldhands, as well as professors, to come together and develop strategies for urban mental health programs. It is hoped that such efforts will result in patterns of organization and utilization which increase the level of agency commitment and optimism on the part of urban staff.

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[19] It should be noted, in regard to the question of initiating change in both rural and urban centers, that new staff members, especially interns, are rarely, if ever, in a position to bring about change. In most cases, change comes about slowly, after one has spent considerable time learning the system and working within it.

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APPENDIX A

ON-SITE INTERVIEW FORMAT USED AT 14 MENTAL HEALTH FACILITIES IN THE SOUTH

Introduction for Staff of Mental Health Facilities

The purpose of my visit here today is to learn something about what it's like to work in a mental health facility. On the basis of the information collected from several different facilities, I hope to make some recommendations about how to influence the distribution of mental health professionals to areas where more are needed.

Your participation is entirely voluntary. You are free to decline specific questions or the interview in its entirety. If you decide to participate, your responses will remain confidential. Neither your name nor the name of this facility will appear in the notes I make or the reports I write. The information you provide will be used only by SREB project staff, without identifiers, and it will be reported only in the aggregate.

Margaret Eisenhart
Teresa Ruff
Southern Regional Education Board

2/80

I. The first questions are about this facility and the services provided here. What you say will give me an idea of what your work here is like.

S1. Please tell me briefly what your job involves.

I. Continued

S2. Of all the things you do here, rank them in order of priority to you.

	S2-1a. What are your reasons for ranking S2a-f ((enter position))?
a.	a1.
	a2.
b.	b1.
	b2.
c.	c1.
	c2.
d.	d1.
	d2.
e.	e1.
	e2.
f.	f1.
	f2.

A. FOR DIRECT SERVICE WORK

S3a. Who else here does work similar to yours?
(Probe: Under what circumstances would someone do work similar to yours?)

B. FOR SUPERVISORY WORK

S3b. How is work allocated among your staff?

I. Continued

A. ((If there is some overlap))
S4a. How do you decide who will do what?

B.
S4b. If a position on your staff were vacant, what kind of person would you look for to fill it?

S5. From your experience, can you give me a feel for how treatment or service programs are determined and monitored?
((Interviewer: Work toward specifics of respondent's role in decision-making process.))

I. Continued

S6. Okay, now I'd like you to think for a minute about the overall operation of this facility. If you were able to expand or redesign the operation of this facility, what particular things would you do?

a1. _____

b1. _____

c1. _____

d1. _____

e1. _____

S7. In general, how would you describe the atmosphere of this facility as a place to work?

74

II. The next questions are about your friends, your interests, and your activities. Your answers will give me a feel for how work fits in with the rest of your life.

S8. With whom on the staff do you feel personally close ?	S9. Who is _____?	S10. What do you and S8a-x talk about when you're together? (Probe: What else will you and S9a-x probably talk about?)
a1.	a1.	a1.
a2.	a2.	a2.
b1.	b1.	b1.
b2.	b2.	b2.
c1.	c1.	c1.
c2.	c2.	c2.
d1.	d1.	d1.
d2.	d2.	d2.
e1.	e1.	e1.
e2.	e2.	e2.
f1.	f1.	f1.
f2.	f2.	f2.
g1.	g1.	g1.
g2.	g2.	g2.

II. Continued

S11. What things do you often do in your free time?	S12. Who do you usually S11a-x with?	S13. Who is S12a-x?
a.	a1.	a1.
	a2.	a2.
b.	b1.	b1.
	b2.	b2.
c.	c1.	c1.
	c2.	c2.
d.	d1.	d1.
	d2.	d2.
e.	e1.	e1.
	e2.	e2.
f.	f1.	f1.
	f2.	f2.
g.	g1.	g1.
	g2.	g2.
h.	h1.	h1.
	h2.	h2.

III. The final set of questions has to do with why you took this position and what things might affect your decision to either stay here or take another position. Your responses will give me some information about what you like and dislike and how this position fits into the plans you have for your life and career.

S14. How long have you worked in your present position? (years) (months)

S15. What other jobs have you had in the past five years?

a1. _____

b1. _____

c1. _____

d1. _____

e1. _____

S16. How long did you work at _____?

a1. _____

b1. _____

c1. _____

d1. _____

e1. _____

77

S17. Where did you live while you were growing up, for the most part?

a1. _____

b1. _____

c1. _____

S18. Where did you go to school (college and post-college)? ((Note highest degree obtained.))

a1. _____

b1. _____

c1. _____

S19. What brought you to this area? ((If not already obvious))

a. _____

b. _____

c. _____

S20. How did you learn about this position (or your first position here)?

a1. _____

b1. _____

c1. _____

d1. _____

S21. What particular things attracted you to this position in the first place?
(Probe: What particular things influenced your decision to take this job?)

a1. _____

b1. _____

c1. _____

d1. _____

S22. To what extent have your initial expectations about your job here been borne out?

a1. _____

b1. _____

c1. _____

d1. _____

S23. What is the most rewarding aspect of your work here?

a1. _____

_____

_____

b1. _____

_____

S24. Why is _____ rewarding?

a1. _____

a2. _____

a3. _____

b1. _____

b2. _____

b3. _____

III. Continued

S25. What is the most frustrating aspect of your work here?

a1. _____

_____

b1. _____

_____

_____

S26. Why is _____ frustrating you?

a1. _____

a2. _____

a3. _____

b1. _____

b2. _____

b3. _____

S27. This question has to do with how seriously you have considered looking for a job somewhere else. During the past year, would you say you have considered this:

a. not very seriously?
b. somewhat seriously?
c. Very seriously?

((If a. or b.))

S28. What particular things might influence you to more seriously consider looking for another job?

a1. _____

b1. _____

c1. _____

d1. _____

e1. _____

III. Continued

S29. ((If b. or c.))
What particular things might influence you to more seriously consider staying here?

a1. _____ _____

b1. _____

c1. _____

d1. _____

e1. _____

S30. If you were to look for another position, where would you probably look?

a1. _____

b1. _____

c1. _____

d1. _____

Thank you very much for answering these questions. Is there anything else I should think about as I do this project? Do you have any questions for me? (Record these on a separate sheet.)

Site Visit#: _____

Facility ID#: _____

Respondent's ID#: _____

Respondent's Sex: _____

Respondent's Color: _____

Respondent's Age: _____

APPENDIX B

SURVEY MATERIALS SENT TO 90 MENTAL HEALTH FACILITIES IN THE SOUTH

Southern Regional Education Board *1340 Spring Street, N. W. • Atlanta, Georgia 30309 • 404 875-9211*

May 23, 1980

Enclosed please find the materials for the SREB project on the organization and utilization of professional staff in rural versus urban mental health facilities.

recommended your facility to participate in this project. Thank you for your interest.

The materials we have sent consist of three items:

1 - An introduction (blue) which summarizes the project and describes the purpose of the other materials;
2 - A form (beige) for recording information about the staffing of your facility;
3 - Envelopes containing materials to distribute to the members of your staff.

In the case of the facility staffing form, we anticipate that you or (in the case of large facilities) someone in your personnel department will be able to provide the information. Please note that we are asking you to report on only direct service staff and supervisors. These staff members are also the ones who should receive the enclosed staff materials.

Thank you for agreeing to participate. Please do not hesitate to contact us if you have questions concerning this project.

Yours truly,

Harold L. McPheeters, M.D.
Director, Commission on Mental Health and Human Services

Joe R. Harding, Ph.D.
Project Director, Distribution of Mental Health Professionals

Margaret A. Eisenhart, Ph.D.
Research Associate, Distribution of Mental Health Professionals

Teresa C. Ruff
Research Associate, Distribution of Mental Health Professionals

INTRODUCTION TO THE PROJECT

STAFF ORGANIZATION,

RETENTION AND RECRUITMENT IN MENTAL HEALTH FACILITIES

A major current concern in the mental health manpower field is that of the distribution of mental health professionals. The Mental Health Program of the Southern Regional Education Board (SREB) has received funding from NIMH to study the distribution of mental health professionals in the South and to develop an action project to address this issue.

This project consists of two major parts. The first part focuses on the influence of training programs on their graduates' choices of type and location of practice. Some of you may have already participated in the first part by completing a questionnaire sent to recent graduates of mental health training programs in the South. This material is being analyzed now. The second part of the project is an exploratory study of the ways mental health staffs are organized and utilized and the factors in organization and utilization which impact on retention and recruitment of staff. In particular, this project focuses on the differences between rural and urban facilities with respect to staff organization, utilization, and work climate.

The materials you have received are about the second part of the project. After visiting a small sample (N=15) of mental health facilities around the region in order to observe firsthand and to talk with mental health professionals, we are now beginning a somewhat larger survey of facilities by sending out questionnaires based on findings from our visits.

This survey has two parts. The first is a survey of the staffing patterns of your facility as a whole. This part of the survey has been sent to the director or superintendent of your facility. In this part, we are interested in learning (1) what kinds of mental health personnel, and (2) in what capacity mental health personnel, are being used in psychiatric hospitals and mental health centers. Also, we hope to learn (3) about the retention and recruitment policies and procedures that are being utilized across the region to attract professionals to hospital and center work.

The second part of the survey consists of questionnaires to be filled out by individual staff members of the participating facilities. This questionnaire asks about the kind of work you actually do (as opposed to, for example, what your job description says you do) and about how you feel about your job and the organization and atmosphere of the facility where you are working. If you participated in Part 1 of this project, a few of the standard questions about yourself (e.g. your age, sex) are repetitive, but the majority of questions are different and focus on your current job rather than on your educational experiences. Your responses to these questions about your work and your facility will allow us to extend our findings to a greater number of facilities than would be possible on the basis of our visits alone (and, of course, we cannot visit every facility).

Your answers to these questions will remain confidential. Self-addressed envelopes have been enclosed so that you may return the forms directly to us. Findings from this survey will be reported only in the aggregate and no information by which you or your facility could be personally identified will be used.

Your participation is, of course, voluntary. However, we feel that this research is important--it has the endorsement of the major national professional associations and the cooperation of all 14 states of the SREB region. Your facility has been selected as one of six to represent your state.

Because we are interested in the characteristics of the facility as a whole, rather than in the characteristics of individual staff members, it is important that every direct service (or supervisory) staff member complete a questionnaire. In pretests, the questionnaire took only 15 minutes; we sincerely hope that you will take the time to complete it.

Reports on findings from this part of the project will be available in the early fall of 1980. Copies will be sent to each participating facility. We look forward to receiving your responses, and your participation will be greatly appreciated.

* * *

Persons wishing further information regarding this project should call or write:

Harold L. McPheeters, M.D.
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Distribution of Mental Health Professionals in the South

SURVEY OF MENTAL HEALTH FACILITIES

STAFF ORGANIZATION, RETENTION, AND RECRUITMENT

TO: Center Directors

As our letter describes, we are interested in learning more about the characteristics of direct service staff members of mental health facilities. In order to compile this information, we would appreciate your preparing the chart on the following pages. The items on the chart are explained in the instructions below.

In Column 1: Please list all of the budgeted direct service positions at your facility for the calendar year 1979.* (Include all clinical service, consultation and education, other community programs, and supervisory personnel.)

In Column 2: Please list the highest degree earned by each person.

In Column 3: Please identify the field in which the highest degree was earned by each person.

In Column 4: Please check the appropriate status of each position during the calendar (or fiscal) year 1979, using the following codes:

F = The position was filled for the entire calendar (or fiscal) year 1979.

V = The position was vacant as of the last day of the year.

VF = The position was vacant during the calendar (or fiscal) year 1979, but was filled prior to the last day of the year.

In Column 5: For those positions marked V or VF in Column 4, please indicate the amount of difficulty experienced in recruiting someone to fill that position.

In Column 6: For those positions marked V in Column 4, please indicate whether or not you were actively recruiting for someone to fill the position.

* If it is easier for you to report this information for a fiscal, rather than a calendar year, please use any fiscal year which ended in 1979.

_____ Check here if you are using a fiscal year.

Column 1 Position Title	Column 2 Highest Degree Earned by Person Holding Position	Column 3 Field in Which Highest Degree Earned*	Column 4 Retention for 1979 See page 1 for instructions Check one			Column 5 If V (vacant) or if VF (vacant but filled) in 1979, how much difficulty did you experience in recruiting someone to fill the position? Check one			Column 6 If V (vacant), were you actively recruiting for someone to fill position? Check one	
			F	V	VF	little	some	a lot	Yes	No
Examples: Director	M.A.	Clinical Psychology								
Social Worker	MSW	Social Work								

* Position Title (Column 1) and Field of Training (Column 3) may in some cases be the same.

Column 1 Position Title	Column 2 Highest Degree Earned by Person Holding Position	Column 3 Field in Which Highest Degree Earned*	Column 4 Retention for 1979 See page 1 for instructions Check one			Column 5 If V (vacant) or if VF (vacant but filled) in 1979, how much difficulty did you experience in recruiting someone to fill the position? Check one			Column 6 If V (vacant), were you actively recruiting for someone to fill position? Check one	
			F	V	VF	little	some	a lot	Yes	No

* Position Title (Column 1) and Field of Training (Column 3) may in some cases be the same.

We are also interested in obtaining your views and policies with regard to recruitment and retention of clinical staff members. The following questions focus on how these are handled at your facility. Your opinions and ideas on these subjects will be greatly appreciated.

A. Recruitment:

There are a variety of methods that a center might use to recruit staff members (i.e., advertisements, personal contacts, etc.). There are also a variety of incentives that might be used to encourage prospects to accept a position (i.e., high salaries, desirable living conditions, employee benefits, etc.). The next questions concern the methods and incentives that are used at your center to recruit new staff members.

1. a. Which methods do you primarily use to recruit personnel for your facility when a position becomes vacant or a new position is created? Please circle all that apply.

1) Advertisement in professional journals
2) Advertisement in national newspapers
3) Advertisement in local newspapers
4) Advertisement in special interest magazines
5) Personal professional contacts
6) Personal contacts
7) Other staff members' contacts
8) State Merit System
9) Private employment agency
10) Other (please specify)

_____

_____

_____

b. Which two methods have proven to be most successful at recruiting <u>good staff members</u> for your facility?

1._____

2._____

2. List two incentives you use to try to encourage good prospects to accept positions at your facility.

1._____

2._____

3. Aside from particular job qualifications, what, in your opinion, are the characteristics of a good staff member for your facility?

_____

_____

_____

_____

_____

_____

4. At this time, what are the most critical needs of your center with respect to additional staff?

B. Retention:
Briefly describe your ideas on retention of professional staff members. We are particularly interested in what formal or informal policy you have with respect to turnover management (e.g., How long do you think a staff member can function well in a given job? Would you like to see changes in your center's professional turnover rate? If so, what changes?).

C. Center Demographics

1. Is this facility located in a rural ( ) or an urban ( ) area?

2. What is the approximate population of the facility's catchment area?

   _____

3. a. Does this facility receive federal funding for staffing? Yes ( ) No ( )

   b. If the answer to a. is YES, how many years remain on your federal staffing grant? _____

4. Total number of employees at this facility _____.

5. How many of the direct service employees (e.g., those you listed above) of this facility are . . .

   a. minority female? _____

   b. minority male? _____

   c. non-minority female? _____

   d. non-minority male? _____

6. Finally, please include a copy of your center's organization chart.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.

Distribution of Mental Health Professionals in the South

SURVEY OF MENTAL HEALTH FACILITIES

STAFF ORGANIZATION, RETENTION, AND RECRUITMENT

TO: Hospital Directors or Superintendents

As our letter describes, we are interested in learning more about the characteristics of clinical service personnel at your hospital. In order to compile this information, we would appreciate your preparing the chart on the following pages. The items on the chart are explained in the instructions below.

In Column 1: Please list all of the budgeted clinical service positions at your facility for the calendar year 1979.*

Include (a) all positions which are filled by individuals who hold degrees above the B.A. or B.S. level. For other categories of clinical (or direct) service staff on your personnel roster(e.g., RN's, LPN's, psychiatric aides, mental health technicians, attendants, or their equivalent), please list every 20th person in each category. If you have less than 20 per category, list the first person on your roster. (For example, if you have 75 LPN's and 19 RN's on your staff, you would list the 20th, 40th, and 60th LPN, and the first RN, for a total of 4).

In Column 2: Please list the highest degree earned by each person.

In Column 3: Please identify the field in which the highest degree was earned by each person.

In Column 4: Please check the appropriate status of each position during the calendar (or fiscal) year 1979, using the following codes:

F = The position was filled for the entire calendar (or fiscal) year 1979.

V = The position was vacant as of the last day of the year.

VF = The position was vacant during the calendar (or fiscal) year 1979 but was filled prior to the last day of the year.

In Column 5: For those positions marked V or VF in Column 4, please indicate the amount of difficulty experienced in recruiting someone to fill that position.

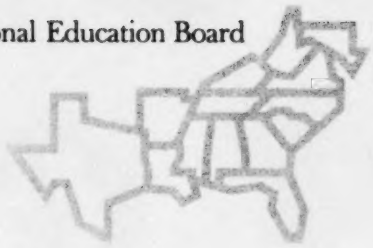
In Column 6: For those positions marked V in Column 4, please indicate whether or not you were actively recruiting for someone to fill the position.

* If it is easier for you to report this information for a fiscal, rather than a calendar year, please use any fiscal year which ended in 1979.

_____Check here if you are using a fiscal year.

Southern Regional Education Board

1340 Spring Street, N.W. • Atlanta, Georgia 30309 • 404 875-9211



May 23, 1980

TO STAFF MEMBERS OF SELECTED MENTAL HEALTH FACILITIES IN THE SOUTH:

Enclosed with this letter is a questionnaire which asks about your job and the organization and atmosphere of the facility where you are working. This questionnaire is part of a project on staffing patterns of mental health facilities in the South. The purposes of the project and the reasons behind the questions we are asking are described in the Introduction to the Project, which is also enclosed.

We are grateful that your facility is participating as a representative of your state. You can help by filling out the questionnaire and returning it directly to us as soon as possible. In pretests of the questionnaire, it took only 15 minutes to complete.

Thank you for your cooperation. Please feel free to contact us if you have any questions concerning this project.

Yours truly,

Harold L. McPheeters, M.D.
Director, Commission on Mental Health and Human Services

Margaret A. Eisenhart, Ph.D.
Research Associate, Distribution of Mental Health Professionals

Joe R. Harding, Ph.D.
Project Director, Distribution of Mental Health Professionals

Teresa C. Ruff
Research Associate, Distribution of Mental Health Professionals

SOUTHERN REGIONAL EDUCATION BOARD
130 SIXTH STREET, N.W.
ATLANTA, GEORGIA
30313

SURVEY OF MENTAL HEALTH PROFESSIONALS

WORKING IN MENTAL HEALTH FACILITIES

Section I.

In order to learn more about how professional staff are utilized and organized to provide mental health services, the first questions are about the tasks you engage in as a mental health professional.

On the following two pages are a number of activities which comprise many jobs in mental health. These activities are divided into two categories. "A." is a list of activities associated with direct service work: "B." is a list of other services provided by mental health professionals.

Please read over the activities. Some activities are more specific than others. When answering the questions on the next two pages, use those activities which best describe what your job involves.

Facility No. ——/ 1-2

Respondent No.————/ 3-6

1. In your work at this facility, are you regularly involved in:

2. For each "yes," which of the following best describes the reason you participate?

*1-It is required by my position.

2-Not required; I really wanted to do it.

3-Not required; someone had to do it.

4-Not required; it was assigned to me.

(Circle the number which best represents your reason.)

3. For each "yes," how do changes usually occur in the way these activities are conducted, monitored, or organized?

1-Through the official chain of command

2-Through political maneuvering by some individuals or groups

3-By agreement of those involved

(Circle the number which best represents your opinion.)

A. Direct Patient/Client Services	(Circle one) Yes?	No?	2.	3.	
a. Psychotherapy - Individual	1	0	1 2 3 4	1 2 3	/99 7-8
b. Psychotherapy - Group	1	0	1 2 3 4	1 2 3	/99 9-10
c. Psychological/Psychopathological Assessment	1	0	1 2 3 4	1 2 3	/99 11-12
d. Staffings/Staff Meetings	1	0	1 2 3 4	1 2 3	/99 13-14
e. Hospital Rounds	1	0	1 2 3 4	1 2 3	/99 15-16
f. Medication Checks	1	0	1 2 3 4	1 2 3	/99 17-18
g. Nursing Care	1	0	1 2 3 4	1 2 3	/99 19-20
h. Provision of Social Services - General	1	0	1 2 3 4	1 2 3	/99 21-22
i. Aftercare	1	0	1 2 3 4	1 2 3	/99 23-24
j. Pastoral Counseling	1	0	1 2 3 4	1 2 3	/99 25-26
k. Occupational Therapy	1	0	1 2 3 4	1 2 3	/99 27-28
l. Recreational Therapy	1	0	1 2 3 4	1 2 3	/99 29-30
m. Other Special Therapies (e.g., movement, dance)	1	0	1 2 3 4	1 2 3	/99 31-32
n. Vocational Rehabilitation	1	0	1 2 3 4	1 2 3	/99 33-34
o. Drug and/or Alcohol Counseling	1	0	1 2 3 4	1 2 3	/99 35-36
p. Other Special Counseling (e.g., marital, sexual)	1	0	1 2 3 4	1 2 3	/99 37-38
q. Special Instruction (e.g., Life Skills, Reality Orientation, classes for special groups such as the mentally retarded, "behavior problems")	1	0	1 2 3 4	1 2 3	/99 39-40
r. Intake	1	0	1 2 3 4	1 2 3	/99 41-42
s. Admissions/Discharge Planning	1	0	1 2 3 4	1 2 3	/99 43-44
t. Other: _____	1	0	1 2 3 4	1 2 3	/99 45-46

*See bottom of Column 2 on next page.

1. In your work at this facility, are you regularly involved in:			2. For each "yes," which of the following best describes the reason you participate? *1-It is required by my position. 2-Not required; I really wanted to do it. 3-Not required; someone had to do it. 4-Not required; it was assigned to me. (Circle the number which best represents your reason.)	3. For each "yes," how do changes usually occur in the way these activities are conducted, monitored, or organized? 1-Through the official chain of command 2-Through political maneuvering by some individuals or groups 3-By agreement of those involved (Circle the number which best represents your opinion.)	
		(Circle one)			
B. Other Activities	Yes?	No?			
u. Case or Clinical Consultation	1	0	1 2 3 4	1 2 3	/99 47-48
v. In-Service Training	1	0	1 2 3 4	1 2 3	/99 49-50
w. Administration (but not Supervision)	1	0	1 2 3 4	1 2 3	/99 51-52
x. Supervision	1	0	1 2 3 4	1 2 3	/99 53-54
y. Research and/or Evaluation	1	0	1 2 3 4	1 2 3	/99 55-56
z. Community Education	1	0	1 2 3 4	1 2 3	/99 57-58
aa. Community Organization/Planning	1	0	1 2 3 4	1 2 3	/99 59-60
bb. Community Consultation	1	0	1 2 3 4	1 2 3	/99 61-62
cc. Advocacy	1	0	1 2 3 4	1 2 3	/99 63-64
dd. Prevention	1	0	1 2 3 4	1 2 3	/99 65-66
ee. Fund-Raising	1	0	1 2 3 4	1 2 3	/99 67-68
ff. Teaching	1	0	1 2 3 4	1 2 3	/99 69-70
gg. Other Consulting	1	0	1 2 3 4	1 2 3	/99 71-72
hh. Service on volunteer, elected or appointed community-based committee as a result of your work in mental health	1	0	1 2 3 4	1 2 3	/99 73-74
ii. Public Relations/Public Speaking in community	1	0	1 2 3 4	1 2 3	/99 75-76
jj. Other: _____	1	0	1 2 3 4	1 2 3	/99 77-78
			* If the activity is officially part of your job, circle 1. Choices 2,3,4, apply to only those activities which are not officially designated as part of your job.	Card No.	0 1 79-80

Section II.

Facility No. ---/ 1-2

Respondent No.----/ 3-6

The next questions are designed to obtain information about recruitment and retention at your facility.

4. a. Have you been working in this facility continuously since January 1, 1978?
(Circle one) Yes....1 No.....0 /9 7

b. If YES, skip to question #5

If NO, where else have you worked since January 1, 1978?

(If you worked more than one other place since then, where else have you spent the most time since January 1, 1978?)

With respect to location? (Circle one)	With respect to type of work? (Circle one)
In the same or a similar location...1	In a public mental health facility (e.g., center, clinic, hospital).....1
In a more urban location.....2	In a private mental health facility.....2
In a more rural location.....3	In private practice.....3
	In a public or private agency involved in mental health.....4
	Outside the field of mental health.....5
	I was in school, training for a job in mental health.....6
	I was in school, but not training for a job in mental health.....7
	I was in the military.....8
	Other: _____ 0 /99 8-9

5. How did you learn about your present position (or your first position with this facility)? (Circle all that apply.)

State Merit System.....1	Professional meeting.....7
Local newspaper.....2	Personal contact.....8
National newspaper.....3	Employment agency.....9
Professional journal.....4	Residency, Internship or Field placement.....10
Other magazine.....5	Placement Center.....11
Professional contact.....6	Other (please specify): _____ 12

/-9-9 10-13

96

Section II. (continued)

6. Below are a number of statements that might be made about why a person was attracted to a particular facility. Please complete each phrase with the two endings that most closely represent your reasons for accepting a position (or, your first position) at this facility.

A. I liked the area (city) because:

(Circle 2)
1. I have family (or friends) here.
2. I went to school here.
3. my spouse was familiar with the area.
4. I like the climate, geography, environment here.
5. there are good cultural facilities here.
6. there are good recreational facilities here.
7. there are several good sources of jobs for myself (and/or spouse) in this area.
8. there are many educational/professional resources in the area.
9. I thought I would like the people here.
10. Other: _____

/-9-9 14-17

B. I was impressed with the facility because:

(Circle 2)
1. there seemed to be good opportunities for professional growth here.
2. I liked the people I met here.
3. the salary and fringe benefits were good.
4. the facility encouraged innovation and autonomy for staff.
5. the facility had a good reputation.
6. I knew someone who worked here and liked it.
7. it was the best facility in the area for me to do the work I wished to do.
8. it was the only facility in the area where I could do the work I wished to do.
9. Other: _____

/-9-9 18-21

C. I was attracted to my first position here because:

(Circle 2)
1. it was the work I was trained for.
2. I anticipated support and encouragement from my colleagues on the job.
3. there was excellent supervision available.
4. there were opportunities for learning new things on the job.
5. there seemed to be opportunity for advancement.
6. at the time, it was the only position in my field in this city (area).
7. it was the work I wanted to do.
8. I saw a need here for someone with my skills and training.
9. the work was very challenging to me.
10. Other: _____

/-9-9 22-25

Section II, (continued)

7. To what extent have your expectations about the job been borne out? (Circle one)

Very well...1 Moderately well...2 Not well...3 /9 26

8. In the past year, how seriously have you considered looking for a job elsewhere? (Circle one)

Very seriously...1 Moderately seriously...2 Not seriously...3 /9 27

9. If you were to leave your present facility, where would you probably go?

With respect to location? (Circle one)

Stay in same location or move to a similar location..1
Move to a more urban location.....2
Move to a more rural location.....3
Don't know.....4

With respect to type of work? (Circle one)

To a public mental health facility (e.g., center, clinic, hospital).....1
To a private mental health facility.....2
Into a private practice.....3
To a public or private agency involved in mental health.....4
To a job outside mental health.....5
Back to school.....6
Don't know.....7
Other: _____ 8 /99 28-29

10. How likely do you feel it is that you could get another, professionally similar, job in your present geographic locale? (Circle one)

Very likely...1 Moderately likely...2 Unlikely...3 /9 30

Section III. *

Listed below are a number of statements. Each represents a commonly held opinion and there are no right or wrong answers. You will disagree with some items and agree with others. We are interested in the extent to which you agree or disagree with such matters of opinion.

Please read each statement. Then indicate the extent to which you agree or disagree by circling the number which corresponds to your opinion. The numbers mean:

1.....I disagree strongly with
2.....I disagree somewhat with
3.....I am uncertain about .....the statement as it applies to my present work
4.....I agree somewhat with in this mental health facility.
5.....I agree strongly with

		Disagree Strongly	Disagree Somewhat	Uncertain	Agree Somewhat	Agree Strongly		
11.	In my work at this facility, I am involved in the same set of activities almost every day.	1	2	3	4	5	/9	31
12.	The people I come in contact with as part of my job are stimulating and interesting to me.	1	2	3	4	5	/9	32
13.	There is always something unexpected happening on this job.	1	2	3	4	5	/9	33
14.	At this facility, my talents and skills could be better utilized than they are now.	1	2	3	4	5	/9	34
15.	I need more equipment or resources to do my job well.	1	2	3	4	5	/9	35
16.	I lack the cooperation I need to do my job well.	1	2	3	4	5	/9	36
17.	I need more specialized training to do my job well.	1	2	3	4	5	/9	37
18.	If I had more opportunities to be creative and innovative, I could do my job better.	1	2	3	4	5	/9	38
19.	In this job, I am constantly struggling to keep my head above water.	1	2	3	4	5	/9	39
20.	I am bored by the work I am now doing.	1	2	3	4	5	/9	40

* In designing this section of the questionnaire, we acknowledge the assistance and previous work of the Research and Evaluation Departments, Northside and Hillsborough Community Mental Health Centers, Tampa, Florida.

Section III. Continued

Please indicate the extent to which you agree or disagree by circling the number which corresponds to your opinion. The numbers mean:

1.....I disagree strongly with
2.....I disagree somewhat with
3.....I am uncertain about .....the statement as it applies to my present work in
4.....I agree somewhat with this mental health facility.
5.....I agree strongly with

		Disagree Strongly	Disagree Somewhat	Uncertain	Agree Somewhat	Agree Strongly	
21.	In my work, I have difficulty using my time the way I want to.	1	2	3	4	5	/9 41
22.	If I had more freedom to make decisions, I could do my job better.	1	2	3	4	5	/9 42
23.	I feel responsible for the things that go wrong around here.	1	2	3	4	5	/9 43
24.	In this job, I have few chances to do the kind of work I really enjoy.	1	2	3	4	5	/9 44
25.	I have opportunities for advancement in this organization.	1	2	3	4	5	/9 45
26.	I have few opportunities to acquire new skills in this job.	1	2	3	4	5	/9 46
27.	Through my work here, I have been able to establish professional ties with colleagues working in other places.	1	2	3	4	5	/9 47
28.	The work I do here is highly regarded by other people working in this facility.	1	2	3	4	5	/9 48
29.	The kind of work I do here is well-respected in my profession or field.	1	2	3	4	5	/9 49
30.	The kind of work I do here is appreciated by people in the local community.	1	2	3	4	5	/9 50
31.	I feel a strong attachment to this facility.	1	2	3	4	5	/9 51
32.	I am committed to the goals of the program (or unit, team, or service) in which I am working.	1	2	3	4	5	/9 52
33.	It is hard to get people here to take on additional activities.	1	2	3	4	5	/9 53

Section III. Continued

Please indicate the extent to which you agree or disagree by circling the number which corresponds to your opinion. The numbers mean:

1.....I disagree strongly with
2.....I disagree somewhat with
3.....I am uncertain about .....the statement as it applies to my present work in
4.....I agree somewhat with this mental health facility.
5.....I agree strongly with

		Disagree Strongly	Disagree Somewhat	Uncertain	Agree Somewhat	Agree Strongly	
34.	Staff members here socialize with each other after work.	1	2	3	4	5	/9 54
35.	There is in-fighting among staff members here.	1	2	3	4	5	/9 55
36.	Staff members here must accept many decisions made by others.	1	2	3	4	5	/9 56
37.	Good working relationships exist among staff members here.	1	2	3	4	5	/9 57
38.	Staff members here are hesitant to go to their supervisors or the director or superintendent when they have problems.	1	2	3	4	5	/9 58
39.	Staff members here have close personal relationships with each other.	1	2	3	4	5	/9 59
40.	New staff members fit in easily here.	1	2	3	4	5	/9 60
41.	Staff members here are in basic agreement concerning the goals and purpose of the facility.	1	2	3	4	5	/9 61
42.	Certain groups of staff are influential in determining what goes on here.	1	2	3	4	5	/9 62
43.	When a staff vacancy occurs in my unit or program, people outside the unit make the important hiring decisions.	1	2	3	4	5	/9 63
44.	The people I work with here are good at their jobs (in other words, they know how to do their jobs and they do them well).	1	2	3	4	5	/9 64
45.	The needs of our client population are well met by the services this facility is providing.	1	2	3	4	5	/9 65

Section III. Continued

Please indicate the extent to which you agree or disagree by circling the number which corresponds to your opinion. The numbers mean:

1.....I disagree strongly with
2.....I disagree somewhat with
3.....I am uncertain about .....the statement as it applies to my present work in
4.....I agree somewhat with this mental health facility.
5.....I agree strongly with

	Disagree Strongly	Disagree Somewhat	Uncertain	Agree Somewhat	Agree Strongly	
46. This facility is highly regarded by clients.	1	2	3	4	5	/9 66
47. Among others in my field, this facility is considered a good place to work.	1	2	3	4	5	/9 67
48. The leaders of this community lack understanding of this facility and the kinds of services it offers.	1	2	3	4	4	/9 68
49. There is stigma (or a negative attitude toward) working in mental health in this community.	1	2	3	4	5	/9 69
50. Administrators and others outside the facility are allowed to interfere with our program here.	1	2	3	4	5	/9 70
51. People want to work at this facility because of its reputation.	1	2	3	4	5	/9 71
52. For most of the staff here now, their chances of getting good jobs elsewhere will be improved as a result of working here.	1	2	3	4	5	/9 72
53. Of the staff members here now, most would prefer working at this facility rather than at another mental health facility in this area.	1	2	3	4	5	/9 73

Skip 74-78

Card No. 0 2 79-80

Section IV.

Thank you for answering the above sections about your job and the facility where you work. The next questions ask for some basic information about yourself. This information will help us understand how you, as an individual, are similar to or different from others who answer our survey.

Facility No. ——/ 1-2

Respondent No.————/ 3-6

54. Your age in years: ....._____ _____/-9 7-8

55. Your sex: (circle one) Female.....1 Male.....2 _____/9 9

56. What best describes your ethnic background? (circle one)

American Indian.....1
Asian/Pacific Islander...2
Black.....3
Chicano/Hispanic....4
White.....5

/9 10

57. What best describes your marital status? (circle one)

Single, never married....1
"Living together".....2
Married/Remarried.....3
Separated/Divorced..4
Widowed.....5

/9 11

58. Number of children now living with you: _____ _____/99 12-13

59. Please estimate the proportion of your life, before accepting your present position, that was spent in each of the following types of communities:

Urban/suburban....._____% /-99 14-16
Small town/rural..._____% /-99 17-19
Small city (25,000-100,000).._____% /-99 20-22

60. In what field is your highest degree? (Circle one. If you have more than one "highest degree," circle all fields that apply.)

Psychiatry.....1
Social work.....2
Human Services.....3
Nursing.....4
Sociology.....5
Clinical Psychology.....6
Counseling Psychology....7
Community Psychology.....8
Other Psychology.....9
Divinity/Theology.....10
Guidance and Counseling..11
Other Education.....12
Other_____13
Other_____14

/-9 -9 23-26

61. What is your job title? _____ _____/-99 27-29

62. In what service, program, or unit do you mainly work? _____ _____/-99 30-32

SUGGESTIONS

The purpose of this project is to generate ideas about what influences people to locate and stay in some practice locations and not others. We are focusing on characteristics of facilities because these are easier to change than other factors, such as the attractions of a geographic area or the size of the place where individuals grow up, which are also associated with retention and recruitment of staff. The ultimate goal is to suggest strategies which facilities might use to improve retention and aid recruitment efforts. As a mental health practitioner, your ideas on this topic can be very helpful. From your experience, what suggestions do you have for ways mental health facilities might reorganize to improve their retention figures and their recruitment success?

THANK YOU AGAIN FOR YOUR PARTICIPATION.

/9 33

Skip 34-78

Card No. 0 3 79-80